

Patient Name _____ Medical Record Number/SS No. _____
Date of Birth _____ Telephone No. _____
Address _____

The undersigned hereby authorizes the use or disclosure of the above named individual's health information as described below.

To be completed by requester: Pick up Mail Other _____
If requested health information is needed for a doctor's appointment, please specify date: _____

The following individual or organization is authorized to make the disclosure:

Physician / Clinic / Hospital _____ Phone _____
Address _____

Date(s) of Service: _____

The type of information to be used or disclosed is as follows:

- Abstract (includes face sheet, history and physical, consults, operative notes, emergency record, lab, radiology, ECG reports, pathology, physical therapy and rehab)
 - 2 years back with most recent test results.
 - 5 years back with most recent test results.
- Other (specify): _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

To Release To: _____ Phone _____
Street Address _____
City, State, Zip _____
For the purpose of _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing, and present my written revocation to the Health Information Manager. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. (Requests may be subject to copying fee.)

Signature of Patient _____ Date _____
Authorized Representative (print name) _____ Relationship to Patient _____
Address of Authorized Representative _____ Phone _____
Signature of Authorized Representative _____ Date _____

Original : Medical Records

Copy: Patient

Copy: Receiving Entity

* 18.00

14*

Olathe Medical Center

20333 West 151st Street
Olathe, Kansas 66061



**AUTHORIZATION TO RELEASE
INFORMATION**

Page 1 of 2

06/03:MSS:mp

O.M.C. No. 24

PLACE
PATIENT LABEL
HERE