

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

**Olathe Medical Services,
Inc**



**AUTHORIZATION
TO RELEASE INFORMATION**

16500 W Indian Creek Parkway
Olathe Kansas 66062

Revised:
06/03:MSS:mp

O.H.S.I. No. 24



HealthPort is contracted with this medical facility to process requests for medical records. Our function is to help the medical facility process their requests quickly, accurately, and in accordance with state and federal laws. We process requests at this medical facility according to a predetermined service schedule. Every effort will be made by the medical facility and HealthPort to process your request on the next scheduled service date.

Records copied will be sent from our centralized print and mail facility. If charges apply to your request, you will receive an invoice from HealthPort. In some cases, you may be required to pay the invoice before the records will be sent out.

Please note the following:

1. There is not a charge associated with requests for records to be sent directly to a doctor or medical facility within the Olathe Medical Services, Inc. (OMSI) system or resulting from a referral from an OMSI physician. Records dating two years back from the most recent date of service will be sent, to include office notes, radiology and testing. Six months of laboratory results will be sent.

2. HealthPort will bill the patient for requested records sent directly to an attorney, disability determination services, insurance companies, medical offices/hospitals outside of the OMSI system, or for the purpose of following a departing OMSI physician, if the request is made by the patient or the patient's representative. Billing for these types of requests are not subject to the special patient pricing and billing will begin with page one.

3. This medical facility has arranged for the following charges for all medical records requested for patient personal review (records are released to the patient):

Pages 1-10...Courtesy Copy will be provided

Pages 11 +...Billed at the state per-page rate (per K.S.A. 65-4791(b)...\$.61 per page, plus shipping and handling. Note: Rates are subject to change with review of the Consumer Price Index.

4. HealthPort will not process requests that are not in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Requests not in compliance will be returned to the requester with an explanation of the reason the request cannot be processed.