Patient Name:		Medical Record No.:	
Date of Birth:		Phone Number:	
Street Address:	City:	State:	Zip Code:

The following organization is authorized to make the disclosure:
☐Olathe Medical Center ☐Miami County Medical Center ☐Olathe Health Physicians, *specify Clinic*: _____
☐Other Physician/Hospital/Clinic *(Home Health & Hospice, Olathe Cancer Care, etc.)*: _____

The type of information to be disclosed:
☐Abstract *(including history & physical, consults, operative notes, emergency record, lab, radiology, and cardiology reports)*
☐Complete Medical Record *(every page of the chart including but not limited to notes, orders, consent forms, etc.)*
☐Clinic Records *(including but not limited to history & physical, consults, clinic records, labs, diagnostic reports, etc.)*
☐Billing Records ☐Radiology (Images Only) ☐Other, *specify*: _____

Date Range of Service: _____ to _____

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

Recipient Name:		Phone Number:	
Street Address:	City:	State:	Zip Code:

For the Purpose of: ☐Continuity of care ☐Legal ☐Personal Records ☐Other, *specify*: _____

Delivery Method: ☐In-Person Pick Up ☐Mail to Recipient Address ☐Fax to: _____
☐eDelivery to Email Address* *(Patient Requests only)*: _____
** I attest that I have provided a valid e-mail address. I understand that a secure link for record access will be emailed to me from a third party release of information vendor. I understand that I have 30 days to access and retrieve my records.*
☐Other Delivery Method, *specify*: _____ If needed for a doctor's appointment, *specify date*: _____

The undersigned herby authorizes the use and/or disclosure of the above named individual's health information as described in this authorization.

- **I understand the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol / drug abuse.**
- I understand that I have the 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 re-disclosure 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 understand that requests may be subject to copying fees.**

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.

Signature of Patient / Authorized Representative _____ Date _____

If signed by Authorized Representative, please complete the following:
Authorized Representative's Printed Name: _____
Relationship to Patient: _____ Phone Number: _____

Department Use Only: *Driver's License or Photo ID required when records are picked up.* Witness Signature: _____
DL State: _____ ID Number: _____ Relationship to Patient: _____ Date/Time: _____

Instructions for completing the Authorization to Release Information:

1. Complete the first section with your current name, date of birth, current address, and daytime telephone number.

2. Select the organization authorized to make the disclosure.

3. Select the records you want.
    a. Billing records are NOT kept in the Health Information Management Department. If you are requesting billing records ONLY, mail this form to the attention of Patient Accounts at 14425 College Blvd., Suite 100, Lenexa, KS 66215 or fax to 913-782-1669. You may call Patient Accounts at 913-355-3798.
    b. Radiology images are NOT kept in the Health Information Management Department. If you are requesting radiology images ONLY, mail this form to the attention of Imaging Department, 20333 W. 151st St., Olathe, KS 66061 or fax to 913-791-4498. You may call Imaging Department at 913-355-5600.

4. Specify dates of service authorized for use/disclosure. Please list specific dates; past year or past two years. If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.

5. Complete the recipient section with the name, address, and contact information of the individual / organization whom you are authorizing disclosure to.
    a. If records are going to be picked up by someone other than the patient, please complete this recipient section for the information of the individual who is picking up the records. A driver's license or photo ID will be required to be shown at the time of picking up the medical records.

6. Specify if the purpose for this disclosure is for continuity of care, legal, personal records or other.

7. Select the method you'd like your records to be delivered in and if applicable, provide the appropriate information in the blank next to your selection. If you select *eDelivery to Email Address*, you are attesting that you have provided a valid e-mail address. A secure link for record access will be emailed to you from our third party release of information vendor. You will have 30 days to access and retrieve your records. If you need access after this time frame, you will have to resubmit your request. Number of pages released for in-person pick up may be limited.

8. This form should be signed and dated by the patient. If the patient is unable to sign and the request is being made by an authorized personal representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate, etc.), the Authorized Representative should sign and date the form. Please provide printed name and relationship to the patient. Supporting legal documentation must accompany this form when signed by an Authorized Representative.

For more information **OR** if you would like to complete a request electronically, please visit our website at https://www.olathehealth.org/patients-and-visitors/medical-records/

If you have further questions, you may contact Health Information Management at (913) 791-4331.

Please submit your completed form to:

Olathe Health Systems
Attn: HIM
20333 W. 151st St.
Olathe, KS 66061

E-Mail: ROI@olathehealth.org

Fax: (913) 791-4335