AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

****PLEASE NOTE: Fees may apply- See below for details****

This Form Must Be Completed in Its Entirety to Be Accepted

Patient Name: _____ AKA: _____

Date of Birth: _____ Phone: H) _____ W) _____

Address: _____ City/State/Zip _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Physician/Medical Office: **KC Bariatric**

Street/Suite: **23401 Prairie Star Parkway, Suite 300** Telephone: **913-677-6319**

City/State/Zip: **Lenexa, KS 66227** Fax: **913-677-1540**

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

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 abuse.

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

Release To: _____

Street/Suite: _____

City/State/Zip: _____

Fax: _____ Phone: _____

Dates and Type of info to disclose:
[] Abstract (pertinent information)
[] Specific Records Only:

_____

Purpose of Disclosure (required):

_____

I understand that I have a right to revoke this authorization at any time in writing to the Healthcare Provider releasing my records. 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 1 year 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 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized 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 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.

⇨ Copy Fee Applies

X _____ _____
Signature of patient / Parent / Guardian or Authorized — Date

Complete if signed by someone other Than the patient.

_____ _____
Printed name of Authorized Representative* — Relationship / Capacity to patient

_____
Address and telephone number of authorized representative

***Guardian or Authorized Representative must attach documentation of such status**

Please Note: This medical practice contracts with ADVANTMED to copy and provide all medical records requested from their facility. We reserve the right to charge for our services pursuant to HIPAA (Federal Statute 45 CFR 164). Patient summaries for transfer of care will be sent for initial visit at no charge. Patient will be billed for any further medical record transfer For more information, please contact them at 855-514-2378.