ASSOCIATES IN FAMILY MEDICINE
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Kansas City, Kansas 66112-1646
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AUTHORIZATION TO RELEASE RECORDS

(A photocopy charge may be incurred for requests.)

Patient Name: _____

Address: _____

Social Security #: _____ Home Phone: _____

Date of Birth: _____ Cell Phone: _____

I hereby authorize Associates in Family Medicine, P.A. to **(RELEASE ☐ / OBTAIN ☐)** photo copies of medical records concerning the above named patient.

To or From: _____

Address: _____

Phone/Fax: _____

Reason for request: _____

Restrictions: *Only medical records that have originated through this health care facility will be released.*

This authorization releases the photocopies of all medical records, x-rays, along with all confidential HIV/AIDS-related information, confidential communicable disease related information, confidential alcohol or drug abuse related information, and confidential mental health diagnosis / treatment information.

This consent expires after (60) days, unless noted. 90 DAYS ___, 120 DAYS ___, Indefinitely ___.

I acknowledge that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Associates in Family Medicine, P.A. in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this is considered acceptable in lieu of the original.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PARENT/LEGALLY AUTHORIZED REPRESENTATIVE DATE

_____ _____
WITNESS DATE