Providence Medical Center

Release of Information

Patient Name: ______________________________ **Date of Birth:** ______/______/______

Address: ______________________ **City:** ______________ **State:** ______ **Zip Code:** ________

Cell Phone: ______________________ **Home Phone:** ______________________

I request my protected health information from Providence Medical Center – Kansas City KS

1. Who will we be releasing your protected health information (PHI)/medical records to?

Name: ____

Address: ______________________ **City:** ______________ **State:** ____ **Zip Code:** _______

2. How would you like the medical records delivered:

- ☐ **Email:** ______________________
- ☐ **Faxed to:** (   ) -   -
- ☐ **Pick up in Medical Records**
- ☐ **Mailing Address:** ______________________ **City:** ______________ **State:** ____ **Zip Code:** _______

3. Dates of Service

Specific Date (s): ______________________**to**______________________

4. I authorize the following PHI to be released for

- ☐ Emergency Room Record
- ☐ Discharge Summary
- ☐ Hospital Summary (transcribed reports/lab/radiology)
- ☐ Operative Report
- ☐ Consultants
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Cardiology Reports
- ☐ Pathology Reports
- ☐ Sleep Study Records
- ☐ Other: please specify_____
- ☐ History and Physical
- ☐ Detailed Billing
- ☐ Radiology Films
- ☐ Pathology Slides
- ☐ Cardiovascular images

5. Purpose for requesting information:

- ☐ Legal
- ☐ Insurance
- ☐ Personal
- ☐ Continuation of Care

6. By signing this authorization form, I understand that PHI may include records relating to mental health, HIV/AIDS, and/or of alcohol/drug abuse.

Patient/Authorized Representative Signature; ______________________**Date:** _____/_____/_____**Time:** ______

Printed name of Authorized Representative: ______________________**Relationship to Patient:** ___________

Witness Signature: ______________________ **Date:** _____/_____/_____**Time:** _________

- ☐ **Copy of Photo ID**
- ☐ **Matching Signature**
- ☐ **Other**____________________

Medical Records Phone Number: 913-596-4178

Fax Number: 913-596-4461

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and Missouri law prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. REV. 04-2018

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