

Infectious Disease Associates of Kansas City, P.C.
AUTHORIZATION TO RELEASE AND/OR RECEIVE RECORDS

Patient Name: _____
Date of Birth: _____ Soc.Sec.#: _____ - _____ - _____ Phone: _____
Address: _____

I hereby authorize Infectious Disease Associates of Kansas City, P.C. to:

- release copies of billing or medical records to the following persons or entities
- receive copies of billing or medical records from the following persons or entities

fill in name and address: _____

The following information shall be obtained and/or released pursuant to this Authorization:

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Radiology Report
<input type="checkbox"/> Billing Records	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Entire Medical Record Set	

Information may be released in writing, verbally, or by video, fax, photocopy, or microfilm.

I request that the above information be released for the following date(s) of service:

NOTICE TO PATIENT/PATIENT REPRESENTATIVE: If the recipient of the information disclosed pursuant to this Authorization is not a health care provider, health plan or health care clearinghouse, the information may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

The information will be obtained and/or disclosed for the following reason(s):

<input type="checkbox"/> Treatment/Continuity of Treatment	<input type="checkbox"/> Legal Reasons
<input type="checkbox"/> AT THE REQUEST OF THE INDIVIDUAL	<input type="checkbox"/> Assessment & Evaluation
<input type="checkbox"/> Other (Specify):	

This authorization will automatically expire 1 year from the date it is signed unless the box below is checked and another expiration date or event is specified.

expiration date/event: _____

This Authorization may be revoked by notifying our Privacy Officer in writing at the following address:

Gail C. Williams, Privacy Officer
Infectious Disease Associates of Kansas City, P.C.
6400 Prospect, Suite 392
Kansas City, Missouri 64132

Note: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by our Privacy Officer.

Patient Signature

Date

Personal Representative's Signature

Date

Personal Representative's Relationship/Authority

This Authorization is voluntary. A refusal to sign will **not** affect the patient's ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits.