

Authorization for RELEASE OF MEDICAL RECORD INFORMATION

Patient Name _____ Date of Birth _____

Address _____

(incl city/state/zip)

Phone _____

Please note there may be a charge for these

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

Mokscare ... Robert Otto, PMHNP
7450 Quivira Rd, Shawnee, KS 66216
Phone: (913) 706-2508 Fax: (913) 543-4444

Dates and Type of Information to disclose

_____ 2 years prior from last seen date

_____ Dates _____

_____ Labs _____

_____ Other _____

Purpose of Disclosure

_____ Change of Insurance or Physician

_____ Continuation of Care

_____ Referral

_____ Other _____

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 records may include information related to STDs, AIDS, or HIV. It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

This information may be disclosed and used by the following individual/organization. Please mail or fax records to the following:

Facility Name _____

Address _____

(incl city/state/zip)

Phone _____ **Fax** _____

I understand the following: I may revoke this authorization at any time; that if I revoke this authorization, I must do so in writing and present my written revocation to the HIM department; that the revocation will not apply to information that has already been released in response to this authorization; that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of information is voluntary and I can refuse to sign this authorization. I don't have to sign this form to obtain 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.

Patient Signature _____ Date _____

Witness _____ Date _____

