## Authorization for RELEASE OF MEDICAL RECORD INFORMATION

**Patient Name** _____ **Date of Birth** _____

**Address** _____

**Phone** _____

**Please note** there may be a charge for these

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

**Facility Name**

**Address** _____

(incl city/state/zip)

**Phone** _____ **Fax** _____

| **Dates and Type of Information to disclose** | **Purpose of Disclosure** |
|---|---|
| _____ 2 years prior from last seen date | _____ Change of Insurance or Physician |
| _____ Dates _____ | _____ Continuation of Care |
| _____ Labs _____ | _____ Referral |
| _____ Other _____ | _____ 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:

**Mokscare Psychiatry**
**7450 Quivira Rd, Shawnee, KS 66216**
**Phone: (913) 706-2508 Fax: (913) 543-4444**

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 _____