Authorization to Release Medical Records

MRN#_____
Account #_____
Completed by_____

Patient Name_____Birth Date: _____/_____/_____
Address_____City: _____State: _____ZIP _____
Phone: _____Email_____

I request my records FROM:

□ Advanced Spine & Brain
□ Cardiothoracic Surgeons
□ Cardiovascular Specialists
□ Ear, Nose & Throat Clinic
□ Excelsior Springs Clinic
□ Kearney Clinic
□ Liberty Clinic
□ Liberty Hospital
□ MU Orthopaedics
□ Plattsburg Clinic
□ Primary Care Shoal Creek
□ Pulmonary & Sleep Clinic
□ Sports Medicine
□ Surgeons Clinic
□ Urgent Care
□ Other_____

I request my records be SENT TO:

Name:_____Phone:_____Email:_____
Address:_____CityState:_____ZIP_____
Fax (Healthcare provider only):_____

What records do you want?

□ ***Pertinent** □ Emergency Room Record □ Radiology Reports □ Lab Reports □ Pathology Reports
□ Cardiology Reports □ Radiology/Imaging □ Other (specify): _____

*Pertinent for hospital consists of face sheet, history and physical, discharge summary/discharge instructions, consultations, operative reports, pathology reports, emergency room record, lab reports, radiology reports, EKG reports, and cardiology reports (if available). *Pertinent for Clinics consists of office notes, labs radiology, EKG, or immunizations.

How do you want your records delivered?

Electronic: __Secure email
Other: __Paper __CD ***VIA:*** __US Mail __Pick up at Liberty Hospital

Purpose of request (optional) □ Legal □ Personal □ Insurance □ Continuation of Care

By signing this authorization form, I understand that:

•Requests for copies of medical records and/or non-document material may be subject to copying fees.
•PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
•I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Department.Revocation will not apply to information that has already been released in response to this authorization.
•Unless otherwise revoked, this authorization will expire on the following date/event/condition:_____ If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
•Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
•Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative Signature: _____Date: _____ Time: _____

Printed Name of Authorized Representative: _____Relationship to Patient: _____
If signed by patient's authorized representative, supporting legal documentation MUST accompany this form.