Authorization for Release of Confidential Patient Information: All sections of this form ***MUST*** be completed to be valid

Patient Name: _____Date of Birth: ____/____/_____
Address: _____
Telephone: _____ UH Medical Record Number _____

Covering the periods of healthcare from:

☐ UH Truman Medical Ctr – 2301 Holmes Street, KCMO 64108 ☐ UH Behavioral Health – 300 West 19th Terrace, KCMO 64108
☐ UH Lakewood – 7900 Lee's Summit Road, Kansas City, MO 64139 ☐ JCHD – 313 S. Liberty St, Independence, MO 64050
☐ University Health 1 - 2101 Charlotte St, Kansas City, MO 64108
☐ University Health 2 - 2211 Charlotte St, Kansas City, MO 64108
☐ UH Community Care Grain Valley – 1439 SW Minter Way, Grain Valley, MO 64029
☐ UH Community Care Raytown – 9406 E 63rd St., Raytown, MO 64133
☐ Eastland Medical Imaging - 19000 E Eastland Center Court Suite 100, Independence, MO 64055

I request my PHI be released to:

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Fax (if healthcare provider): _____

I authorize the following PHI to be released from my medical records:

☐ Emergency Room Record ☐ Laboratory Reports ☐ Radiology Reports ☐ Clinic Notes
☐ History and Physical ☐ Discharge Summary ☐ Operative Reports ☐ Progress Notes
☐ Abstract (hospital summary which includes physician reports, labs and radiology) ☐ Complete Medical Record
☐ Other: _____

Covering the periods of healthcare from: ____/____/_____ to ____/____/_____

Purpose of requesting information:
☐ Legal ☐ Insurance
☐ Personal ☐ Continuation of Care
☐ Other: _____

Delivery method:
☐ US Mail (paper) ☐ Fax
☐ CD
☐ Email (not secure & dependent on record size)
_____

By signing this authorization form, I understand that:

- PHI may include records relating to mental health care, communicable disease, 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 Release of Information department. Revocation will not apply to any information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization shall expire within six months of 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 re-disclosures, and the information may not be protected by federal confidentiality rules

Patient/Authorized Representative Signature: _____Date: ____/____/_____
☐ **Check box if obtaining verbal consent***
The dates covered by this request will be the beginning date listed above, through the date this authorization is signed

Printed Name of Authorized Requestor: _____Relationship to Patient: _____
*Employee Signature: _____ Date: _____
*Witness Signature: _____ Date: _____
***Required if obtaining telephone consent or if patient is physically unable to sign consent**

PROHIBITION ON DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. You have the right to view and receive copies of certain portions of your medical & financial records kept by University Health or our business associates. You may not view or receive copies of any psychotherapy notes as that term is defined in 45 C.F.R. Sec. 164.501, information restricted under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records.

Truman Medical Center, Incorporated d/b/a University Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-816-404-3280 (TTY: 1-816-404-0002)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-816-404-3280 (TTY: 1-816-404-0002)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- **816-404-3280**(رقم هاتف الصم والبكم: 1-**816-404-0002**)

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