

REQUEST FOR RELEASE OF MEDICAL RECORDS

JOHNSON COUNTY OB/GYN, CHART.

7440 W. Frontage Merriam, KS 66203
913.236.6455 Fax: 913.236.6678

DR. CRANSTON CEDERLIND** DR. RANDY SHERIDAN** DR.MELANIE MARTIN**DR. CHRISTOPHER LYNCH**
DR. RONALD BARNHART** DR. LARRY BATTY** DR. CORINNA COOPER**
STACY FORD, WHNP**PAM NICHOLSON, A.R.N.P.

NAME (PLEASE PRINT): _____
(FIRST) (MI.) (LAST)

D.O.B. _____ **SSN:** _____ **CONTACT NUMBER** _____

I, _____, WOULD LIKE MY RECORDS TO BE
(NAME)

_____**TRANSFERED TO:**

_____**TRANSFERED TO:**

JOHNSON COUNTY OB/GYN
7440 W FRONTAGE RD.
MERRIAM, KS 66203

(NAME OF PHYSICIAN OR HOSPITAL)

(NAME OF PHYSICIAN)

(PHYSICIANS ADDRESS)

(PHONE / FAX NUMBER)

FROM:

FROM:

(NAME OF PHYSICIAN)

JOHNSON COUNTY OB/GYN
7440 W. FRONTAGE RD.
MERRIAM, KS 66203

(PHYSICIANS ADDRESS)

(PHONE / FAX NUMBER)

(NAME OF PHYSICIAN)

MEDICAL INFORMATION YOU NEED:

___ ALL RECORDS ___ 3-5 YEARS BACK ___ MOST RECENT PAP ___ MOST RECENT LAB/ULTRASOUND

___ OTHER: _____

REASON FOR REQUEST:

___ PCP ___ TRANSFERING CARE ___ MOVING ___ INSURANCE ___ OTHER _____

I understand that the records to be used or disclosed pursuant to this authorization may contain certain records relating to participation in federally assisted drug and alcohol abuse programs; information relating to diagnosis and treatment of mental health (such as depression), alcoholic or drug counseling session provided such notes are maintained separately; information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to 45 C.F.R. 164.508; 42 C.F.R. Part 2; K.S.A. 65-5601 et seq.; and K.S.A. 65-6001 et seq. By my signature below I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

At this time, I understand that this authorization may be revoked in writing by me at any time, except to the extent that this action has been taken. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I also understand that if the requester or receiver of my medical records is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE IN ONE YEAR FROM THE DATE OF SIGNATURE EXCEPT AS SPECIFIED: _____

(PATIENT SIGNATURE OR LEGAL REPRESENTATIVE)

(DATE)

(RELATIONSHIP IF NOT THE PATIENT)

(WITNESS)