

LEE'S SUMMIT PHYSICIANS GROUP, INC
1425 NW BLUE PARKWAY
LEE'S SUMMIT, MO 64086
816-524-3223 EXT 103

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This consent to release information about a patient is intended to satisfy the requirements of Kansas And Missouri law and when applicable, federal law.

I understand that my medical record includes information pertaining to all aspects of my medical care including information regarding all visits to my primary care physician and other providers, including mental health, obstetrics/gynecology, referrals to consultants and inpatient hospitalizations.

Name: _____ Birthdate: _____

Phone: _____
Address _____ City/State _____ Zip _____

Maiden or Former Name: _____

I, the undersigned, hereby authorize _____
PHYSICIAN/ HOSPITAL OR CLINIC

Address _____ City/State _____ Zip _____

to release to _____
(Person or Organization who is to receive information)

Address _____ City/State _____ Zip _____

the following information pertaining to my medical care:

_____ Medical information from _____ to _____

_____ Partial medical record (Please specify part to be released)

_____ Complete medical record

The above-outlined released IS TO INCLUDE information pertaining to:

_____ Alcohol or substance abuse diagnosis or treatment

_____ AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex),
or AIDS antibody test results

_____ Psychiatric/mental health diagnosis or treatment

REASON(S) FOR REQUESTING THIS INFORMATION:

RESTRICTIONS

Any further use or disclosure of the information by the person or organization requesting it is not authorized unless an additional consent is obtained or if permitted by law.

DURATION

This authorization shall be valid until _____ or for one year from the date hereof, whichever occurs first. My consent is subject to revocation at any time except to the extent that action has been taken by Lee’s Summit Physicians Group in reliance upon my consent.

I understand and have been informed of the following:

- I may refuse to sign this authorization and that it is strictly voluntary
- My treatment, payment and enrollment or eligibility for benefits may not be conditioned on signing this authorization
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed
- I understand that I may see and obtain a copy the information described on this form, for a reasonable fee if I ask for it
- I get a copy of this form after I sign it.

Copy requested and received:

Date

Initials

Date

Patient’s Signature

PLEASE PRINT NAME OF
PARENT OR GUARDIAN
SIGNING THIS FORM

Parent, Legal Guardian Signature

Relationship to Patient

PLEASE INDICATE IF YOU ARE LEAVING OUR PRACTICE and will receive medical care from another primary care physician _____ yes _____ no. If yes, please tell us why you are leaving:

NOTE:

This form may be used to obtain medical information by Lee’s Summit Physicians Group, Inc., for use in diagnosing and treating its patients, for release of medical information by Lee’s Summit Physicians Group, Inc., health care providers to other requesting parties, and for the use of Lee’s Summit Physicians Group. If properly directed by the patient, this form can also be used as authorization for the release of sensitive information regarding psychiatric or substance abuse treatment and HIV (AIDS/ARC) related information.

Date Received

Received By