THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160	**Do not write in this box**  	**Medical Record #:** _____ **Account #:** _____

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

(Applies to University of Kansas Hospital Authority, The University of Kansas Physicians & KU HealthPartners, Inc.)

Please print all information except for signatures

(Patient name), _____ born on _____, hereby authorizes (or the patient's personal / authorized representative authorizes) the disclosure of records to:

☐ Me (Patient or personal / authorized representative only. Must provide proof of relationship.)

☐ Other (**List full name and address**): _____

_____

the following records:

Check only those that apply

☐ Discharge Summary ☐ Lab Tests ☐ Pathology Reports ☐ Medications

☐ Operative Reports ☐ Consultation Reports ☐ Radiology/Therapy Reports ☐ Diagnostic Studies

☐ Clinic Notes from _____ Clinic ☐ Billing Records

☐ Specific Dates only from: _____to: _____ (*This helps to identify your specific request.)*

☐ Complete Medical Record of treatment provided at University of Kansas Hospital Authority and The University of Kansas Physicians

☐ KU MedWest ☐ KU MedWest Ambulatory Surgery Center ☐ KU HealthPartners

☐ Other (please specify i.e., outside records, monitoring strips, photos, x-rays, etc.) _____

_____

(If you have any questions as to what is included in any of the above categories, or you do not want a specific report released, contact the Medical Record Department listed below.)

The purpose of this request is: ☐ Continued Care ☐ Insurance/Disability***** ☐ Litigation***** ☐ Personal* ☐ Other_____

***Copy Charges: $18.40 Base fee plus $0.61 per page for the first 250 pages** (Additional pages are $0.44 per page)

- I understand once the above records are disclosed, they may be re-disclosed by the recipient and may no longer be protected by State and/or Federal Privacy Laws.
- My treatment can not be conditional upon completing this authorization form, unless the treatment is for the sole purpose of creating information for disclosure to a third party.
- I understand that I may revoke this authorization in writing by notifying the original recipient of this authorization at any time except to the extent that action has been taken in reliance on it.

SPECIFY THE DATE, EVENT, OR CONDITION UPON WHICH THIS AUTHORIZATION EXPIRES:

_____

(In all cases this "Authorization" will expire one year from the date below.)

SIGNED THIS _____ DAY OF _____, 20_____

_____
ID Verification of Requester (Drivers License or Photo ID)

_____
(*Witness – Office Staff Use Only*)

_____
(Signature of PATIENT or AUTHORIZED REPRESENTATIVE)

_____
(Print Name of Representative & Nature of Relationship)

_____
(Address of Person Signing Authorization)

_____
City State Zip

(_____)_____-_____
Day Time Telephone

Send completed form to the following address:

University of Kansas Hospital
Health Information Management Dept.
P.O. Box 2509
Shawnee Mission, Kansas 66201
Phone: (913) 588-2454