

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

City, State, Zip: _____

The undersigned hereby authorizes the following health care professional:

Physician's name: _____

Street Address: _____

City, State, Zip: _____

To release the following information and dates of service:

All records Date(s): _____

Lab only Date(s): _____

X-Rays only Date(s): _____

Other Date(s): _____

To:

Overland Park Family Health Partners, P.A.
6740 W. 121st Street
Overland Park, Kansas 66209
913-894-6500

I understand that my medical records (including any psychiatric, alcohol, or drug abuse information) may be protected by federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (IE: probation, parole, etc.). This consent expires automatically as described below. I understand that my records may contain information regarding the diagnosis or treatment of HIV, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Unless otherwise specified, this consent will be valid for 60 days from the date of signature.

Patient's Signature: _____

Date: _____

Signature of parent/guardian (if under 18) _____

Date: _____

Signature of representative (if not parent/guardian): _____

Date: _____

If representative, what is your relationship to the patient? _____

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality may be protected by Federal Law. Federal regulations prohibit 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.