

Kansas City Bone & Joint Clinic, PA
10701 Nall Suite 200
Overland Park, KS 66211
Phone: 913 381-5225
Fax: 913-901-0186

Medical Record Release Authorization

Patient Name _____ Maiden Name _____ SS# _____

Date of Birth _____ Home Phone _____ Cell/Work _____

Address _____ City/State/Zip _____

Email Address: _____

A) I hereby authorize records FROM:

Name _____

Address _____

City/State/Zip _____

Phone# _____ Fax# _____

B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone# _____ FAX# _____

C) For the purpose of:

D) Records Format: Records will always be delivered via user friendly CD or secure fax unless notated here:
 Please send printed copies via postal mail

Date Range _____ to _____

Physicians Office Notes

Xray Films

Operative/Procedure Reports

Other _____

Cardiology/EKG Reports

Lab/Path Reports

Radiology/XRay/MRI Reports

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

(Date) _____
(Signature of Patient/Parent/Guardian or Authorized Representative) ****Subject to Fees**

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

***PLEASE READ Fee Information:** Kansas City Bone & Joint Clinic, PA contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by the State of Kansas. A \$18.40 handling fee, \$0.61 cents per page and postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.