

## MEDICAL RECORDS RELEASE

Intended Use: This form should be used as defined in Policy 5.08: Authorization to Release

Health Center:	
Patient Name:	Birth Date:
Employee ID # or Last 4 Digits of Social Security No.:	Medical Record (MMI) No.:
Address:	Telephone No.:
I hereby authorize the above-referenced entity to release the medical information about me indicated below to the following recipient:  Recipient Name:  Telephone No.:	
Address:	Fax No.:
	I da No
Documents Needed:	
☐ Entire Record (no films) ☐ EKG Reports (no films) ☐ History & Physical ☐ Pathology Reports	☐ Cardiovascular Reports ☐ Operative / Procedure Reports
☐ Laboratory Results ☐ Anesthesia Records	☐ Discharge Summary
☐ Emergency Department Needs ☐ Consultation Records	<ul><li>Mammography Reports (no films)</li><li>Other:</li></ul>
Dates of Service Needed:	
□ All □ Last Visit Only □ From:/ To:/	
Purpose of Release:	Insurance
Continued Care *     Disability	Personal
<ul><li>Legal (Attorney)</li><li>Dept. Children's &amp; Fam (DCFS)</li></ul>	ily Services   Other:
* If for continued care, records needed for doctor's appointment on (date) at (time).	
<ul> <li>Please fax completed Medical Release to 816-936-1918 or to 1-800-290-1024</li> <li>For questions related to a submitted Medical Release request please call 866-220-0089</li> </ul>	
I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmissible diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.	
I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Cerner or the above-referenced entity will not depend in any way on whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization.	
I understand that State and federal law may prohibit the Recipient from re-disclosing information provided pursuant to this Authorization, but that neither Cerner nor the above-referenced entity has any control over the Recipient and cannot, therefore, guarantee that the Recipient will not re-disclose such information. I hereby release Cerner and the above-referenced entity from any and all liability related to (i) their reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.	
I understand that the above-referenced entity may charge me reasonable, cost-based fees for such records of up to \$1.00 per page for paper records (up to \$2.00 per page for non-paper records) and an administrative fee of \$1.00 for each year of records requested. The above-referenced entity will waive such fee for copies provided to another healthcare provider for continuing care or for work related health care.  By signing below, I authorize the entity checked above to release medical information about me as described above.	
Signature of Patient Da	ate
If the patient is (i) a minor, the patient's parent should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:	
Signature of Representative	Telephone
Name of Representative F	Relationship to Patient