CONSENT FOR RELEASE OF MEDICAL INFORMATION
From an outside facility to KCWC

ACCOUNT #_____ _____ DOB:_____

I, _____ _____, authorize and request:
(Print Name)

Physician's Name: _____

Physician's Street Address: _____ City/State: _____ Zip_____

To disclose to: Medical Records Department / Kansas City Women's Clinic
10600 Quivira Road, 3rd Floor
Overland Park, KS 66215

The following medical record: specifically describe the information to be released, such as dates (s) of service, level of detail to be released.

_____

- ☐ All of my medical records EXCEPT those relating to care and treatment for mental health conditions, drug or alcohol abuse, or HIV testing, infection status, or care and treatment for AIDS.
- ☐ All of my medical records INCLUDING the following:
  - ☐ Relating to care and treatment for mental health conditions
  - ☐ Relating to care and treatment for drug or alcohol abuse
  - ☐ Relating to HIV testing, infection status, or care and treatment for AIDS

For the purpose of _____
(Reason for Disclosure)

I understand this consent may be revoked in writing at any time except to the extent already acted upon. My written revocation must be submitted to Kansas City Women's Clinic. This consent expires on _____.

I do not have to sign this authorization in order to receive treatment from Kansas City Women's Clinic. In fact, I have the right to refuse to sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

_____
Signature of Patient or Authorized Representative Date

_____
Patient's name as known by provider of medical records. (Please Print)