AUTHORIZATION TO RELEASE/DISCLOSE MEDICAL RECORDS

Individual Information

Patient Name: _____ Date of Birth: _____

Information May Be Disclosed BY:

Name of provider, or organization releasing information: _____
Address: _____ Suite/Apt#: _____
City: _____ State: _____ Zip:_____
Fax: _____ Phone: _____

Information May Be Disclosed TO:

Integrative Medical Specialists
25055 W Valley Parkway, Suite 204
Olathe, KS 66061
Phone: 913-825-6111 Fax: 913-825-6115

I Hereby Release The Following Medical Records: (Copy Fees May Apply)

___ Please send entire medical records
___ All hospital records
___ Medical records necessary for continuity of care
___ Laboratory reports/results
___ Clinical records from _____/_____/_____ to _____/_____/_____
___ Diagnostic imaging reports
___ Most recent five year history
___ Pathology reports
___ Clinician office chart note
___ Other _____

This Information Is To Be Released For:

___ Medical records necessary for continuity of care
___ Doctor/Health Care Provider
___ Personal
___ Insurance
___ Attorney/Legal
___ Other _____

The Following Items Require Initials To Be Released:

___ HIV/AIDS related records
___ Drug/Alcohol diagnostics, treatment or referral information
___ Mental Health information
___ Genetic testing information

Federal regulations require a description of how much information and what kind of information is to be disclosed.)
Describe: _____

This authorization expires 180 days from the date signed or on the date of event indicated here: _____

Rights

I understand that I may revoke this authorization at any time in writing. I also understand that the written revocation must be signed and dated later than the date of this authorization. If I revoke my authorization, it will not affect any actions already taken by Integrative Medical Specialists, LLC. Once the information I have authorized to be disclosed is disclosed, it may no longer be protected under health information privacy laws.

_____ _____
Patient, Guardian or Authorized Representative Date
(Documentation may be required to prove authority to sign on behalf of the patient)

A minor patient's signature is required to disclose information related to reproductive care, sexually transmitted disease (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

_____ _____
Minor Signature (Required if Minor is Age 13-17) Date

25055 W. Valley Pkwy • Suite 204 • Olathe, KS 66061 • Phone (913) 825-6111 • Fax (913) 825-6115 • www.IMS-KC.com