



JOHNSON COUNTY OBGYN

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Request for Release of Medical Records

PHONE: 913-236-6455 FAX: 913-236-6678

Full Name (PLEASE PRINT): _____

DOB: _____ PHONE: _____

I, _____, would like my records to be:

(Patient's Name)

____ **TRANSFERRED TO:**

____ **TRANSFERRED TO:**

Johnson County OB/GYN

7440 W Frontage Rd
Merriam, KS 66203

(Name of Physician)

FROM:

(Name of Physician)

(Physician's Address)

(Phone/Fax Numbers)

(Name of Physician or Hospital)

(Address)

(Phone/Fax Numbers)

FROM:

Johnson County OB/GYN

7440 W Frontage Rd
Merriam, KS 66203

(Name of Physician)

Medical Information You Need:

___ ALL RECORDS ___ 3-5 YEARS BACK ___ MOST RECENT PAP ___ RECENT LAB/ULTRASOUND

OTHER: _____

Reason for Request:

___ PCP ___ TRANSFERRING CARE ___ MOVING ___ INSURANCE ___ OTHER: _____

I understand that the records to be used or disclosed pursuant to this authorization may contain certain records relating to participation in federally assisted drug and alcohol abuse programs; information relating to diagnosis and treatment of mental health (such as depression), alcoholic or drug counseling session provided such notes are maintained separately; information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to 45 C.F.R. 164.508; 42 C.F.R. Part 2; K.S.A. 65-5601 et seq.; and K.S.A. 65-6001 et seq. By my signature below I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

At this time, I understand that this authorization may be revoked in writing by me at any time, except to the extent that this action has been taken. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I also understand that if the requester or receiver of my medical records is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE IN ONE YEAR FROM THE DATE OF SIGNATURE EXCEPT AS SPECIFIED: _____

(Patient Signature OR Legal Representative)

(Date)

(Relationship IF NOT THE PATIENT)

(Witness)