

**REQUEST FOR RELEASE OF MEDICAL RECORDS
JOHNSON COUNTY OB/GYN, CHART.**

7440 W. Frontage Rd. Merriam, KS 66203
913.236.6455 Fax: 913.236.6678

**DR. CRANSTON CEDERLIND ♦ DR. RANDY SHERIDAN ♦ DR. MELANIE MARTIN
DR. CHRISTOPHER LYNCH ♦ DR. CORINNA COOPER ♦ DR. ABIGAIL PROFFER ♦ DR. MEGAN BROWN
DR. MEGHAN VAGLIO ♦ STACY FORD, WHNP ♦ PAM NICHOLSON, WHNP ♦ JEN PEPPARD, WHNP**

FULL NAME (PLEASE PRINT): _____

D.O.B.: _____ **SS#** _____ **PHONE #:** _____

I, _____, **WOULD LIKE MY RECORDS TO BE:**
(PATIENT'S NAME)

_____ **TRANSFERRED TO:**

JOHNSON COUNTY OB/GYN
7440 W. Frontage Road
Merriam, KS 66203

(NAME OF PHYSICIAN)

FROM:

(NAME OF PHYSICIAN)

(PHYSICIAN'S ADDRESS)

(PHONE /FAX NUMBERS)

_____ **TRANSFERRED TO:**

(NAME OF PHYSICIAN OR HOSPITAL)

(ADDRESS)

(PHONE/FAX NUMBERS)

FROM:

JOHNSON COUNTY OB/GYN
7440 W. Frontage Road
Merriam, KS 66203

(NAME OF PHYSICIAN)

MEDICAL INFORMATION YOU NEED:

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

OTHER: _____

REASON FOR REQUEST:

___ PCP ___ TRANSFERING 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)