REQUEST FOR RELEASE OF MEDICAL RECORDS

JOHNSON COUNTY OB/GYN

A DIVISION OF MID AMERICA PHYSICIANS SERVICES, LLC.
7440 W. Frontage Rd. Merriam, KS 66203
913.236.6455 Fax: 913.236.6678

♦ DR. RANDY SHERIDAN ♦ DR. MELANIE MARTIN ♦ DR. CHRISTOPHER LYNCH ♦
DR. CORINNA COOPER ♦ DR. ABIGAIL PROFFER ♦ DR. MEGAN BROWN ♦ DR. MEGHAN VAGLIO ♦
JEN PEPPARD, WHNP ♦ STACY CORUM, WHNP ♦ MARIA HAPKE, 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)