JOHNSON COUNTY
OBGYN

Christopher M. Lynch, MD
Corinna A. Cooper, MD
Abigail R. Proffer, MD
Jaclyn Piszczek, MD
Jessica Williams, MD

REQUEST FOR RELEASE OF MEDICAL RECORDS

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 federaly 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)