ST. JOSEPH FAMILY MEDICAL CARE
1004 CARONDELET DR. SUITE 440
KANSAS CITY, MO 64114
OFFICE: (816)943-7777 FAX: (816)943-7778

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

ALL DISCLOSURES ARE IN COMPLIANCE WITH FEDERAL AND STATE LAWS, INCLUDING THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA), GOVERNING THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI).

I HEREBY AUTHORIZE ST. JOSEPH FAMILY MEDICAL CARE TO OBTAIN FROM:

NAME OF PERSON/ORGANIZATION_____

ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE NUMBER _____

FAX NUMBER_____

INFORMATION REQUESTED: I HEREBY AGREE TO THIS AUTHORIZATION & UNDERSTAND & THAT IS MUST CONTAIN PERSONAL IDENTIFIABLE INFORMATION & PHI AS DEFINED BY HIPPA TO ENSURE ACCURACY. I UNDERSTAND I HAVE THE RIGHT TO LIMIT THE TYPE OF INFORMATION RELEASED & TO REVOKE THIS AUTHORIZATION BY SUBMITTING A NOTICE IN WRITING TO THE PRIVACY OFFICER. UNLESS REVOKED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM DATE OF SIGNATURE OR ON THE FOLLOWING DATE_____, IF I CHOOSE TO LIMIT THE INFORMATION RELEASED. I UNDERSTAND THAT GVFP MAY INFORM MAY INFORM THE REQUESTOR THAT PORTIONS OF THE RECORD HAVE BEEN WITHHELD. I UNDERSTAND THE INFORMATION DISCLOSED MAY BE SUBJECTED TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER BE PROTECTED BY GVFP AND THEIR STAFF ARE HEREBY RELEASED FROM ANY LEGAL RESPONSIBILITY, LIABILITY OR DISCLOSURE OF THE BELOW INFORMATION THE EXTENT INDICATED AND AUTHORIZED HEREIN.

_____**ALL** MEDICAL RECORDS WITHOUT THE EXCEPTION, INCLUDING: CLINICAL NOTES, LAB TESTING(INCLUDING HIV), MENTAL HEALTH TREATMENT, ALCOHOL/DRUG ABUSE TESTING & TREATMENT, SEXUALLY TRANSMITTED DISEASE, SECONDARY RECORDS,

OR

_____**PARTIAL** MEDICAL RECORDS WHICH MAY INCLUDE HIV TESTING/TREATMENT, MENTAL HEALTH, ALCOHOL/DRUG ABUSE TESTING & TREATMENT, SEXUALLY TRANSMITTED DISEASE & OTHER SENSITIVE INFORMATION. PLEASE SPECIFY PARTS & DATES TO BE RELEASED:

PROGRESS NOTES: _____
XRAY REPORTS: _____
IMMUNIZATIONS: _____
ALLERGY: _____
LAB REPORTS: _____
GYN REPORTS: _____
PHYSICAL: _____
CONSULTATIONS: _____
OTHER (SPECIFY): _____

FOR THE PURPOSE OF:_____
I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS INDICATED ABOVE.

_____ _____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN | DATE OF BIRTH | SOCIAL SECURITY NUMBER

_____ _____
PRINT NAME | TELEPHONE NUMBER

_____ _____ _____ _____
ADDRESS | CITY | STATE | ZIP

_____ _____ _____
PREVIOUS NAME WHICH RECORDS MAY BE FOUND | WITNESS | DATE

NOTE TO RECIPIENT: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTLY IS PROTECTED BUT FEDERAL & STATE LAWS(INCLUDING HIPPA) & PROHIBITS YOU FROM FURTHER WITHOUT THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. CHARGES MAY APPLY FOR COPIES OF MEDICAL RECORDS. A COPY OF THIS WILL BE FILED IN THE ABOVE NAMED PATIENTS PHI.