THE WOMEN'S HEALTHCARE GROUP
OBSTETRICS & GYNECOLOGY

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO OUR OFFICE

PATIENT NAME_____ BIRTH DATE_____
ADDRESS _____ CITY_____ STATE _____ ZIP _____
HOME PHONE_____ SSN _____
PREVIOUS / OTHER NAMES (MAIDEN / MARRIED)_____

I, THE UNDERSIGNED, HEREBY AUTHORIZE;

_____
(NAME AND TITLE OF PERSON OR ORGANIZATION TO RELEASE INFORMATION)

_____
ADDRESS CITY STATE ZIPCODE

_____
PHONE NUMBER FAX NUMBER

TO RELEASE MEDICAL INFORMATION CONCERNING THE ABOVE NAMED PATIENT TO:

THE WOMEN'S HEALTHCARE GROUP	OFFICE	913-541-0990
10600 QUIVIRA ROAD, SUITE 200	OFFICE FAX	913-541-1452
OVERLAND PARK, KANSAS 66215		

What medical information do you need to have forwarded?(choose one) □ Most Recent Labs □ Last Office Visit □ Last 3 Years □ Entire File □ Other _____

Reason for the Request: □ PCP □ Transferring Care □ Moving □ Insurance □ Continuation of Care □ 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.

*THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF SIGNATURE EXCEPT AS SPECIFIED: _____
(SPECIFIC DAY OR MONTHS)

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 breech 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 my be re-disclosed.

Signature of Patient or Legal Guardian _____ Date _____
Relationship if not the Patient _____
Signature of Witness _____ Date _____