Associated Plastic Surgeons
11501 Granada Lane
Leawood, KS 66211
Phone: 913-451-3722 Fax: 913-451-5000

Medical Record Release Authorization

Patient Name_____Maiden Name_____SS#_____

Date of Birth_____Phone:Home_____Work/Cell_____

Address_____City/State/Zip_____

By completing the following it allows Associated Plastic Surgeons to release your medical records to:

Physician/Medical Office:_____

Address_____ City/State/Zip_____

Phone Number:_____ Fax:_____

Information you would like disclosed:

- ☐ Date Range:_____to_____
- ☐ 2 years back
- ☐ 5 years back
- ☐ Entire Record
- ☐ Other (Be specific as possible):_____

_____

You will be provided with 2 years of history from the date of this release if no criteria above is specified.

☐ Please mail the records to the address provided at the top of this page.

☐ The following organization is authorized to provide Associated Plastic Surgeons my records.

_____

_____

_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus). , other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I gave my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.532. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)

The service charges are set by the State of Kansas K.S.A. 65-4971. A $18.18 handling fee, .60 per page, and postage will be billed to you.