THE UNIVERSITY OF KANSAS HEALTH SYSTEM

4000 Cambridge Street
Kansas City, Kansas 66160

Do not write in this box

DT4068
Request for Records

Medical Record #: _____

Account #: _____

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

All sections of this authorization form MUST be completed to be considered valid

Applies to The University of Kansas Health System- Kansas City and Great Bend Campus

Patient Last Name: _____ **First Name:** _____ **MI:** _____ **Date of Birth:** ___/___/___

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

E-Mail Address: (Optional) _____ **Phone:** _____

I request my records to be sent to :

Name _____

Address: _____ Phone: _____

City/State _____ Zip Code _____ Fax Number: (Health Care Provider Only) _____

E-Mail Address: _____

I request the following PHI to be released from my medical record(s):

Campus: ☐ Kansas City & surrounding areas ☐ Great Bend Campus (Cleveland St) ☐ St. Rose Medical Pavilion ☐ Great Bend Family Medicine (Polk)
☐ Central KS Orthopedic Group

☐ Pertinent (Inpatient Summary which includes physician reports, lab, radiology and other test results)
☐ Emergency Room Record
☐ Clinic records – specify clinic or physician: _____
☐ Lab Reports ☐ Radiology/Imaging Reports ☐ Discharge Summary ☐ Operative/Pathology Reports ☐ Immunizations
☐ Mental Health Records – Includes Inpatient and/or ambulatory office visit notes.
☐ Complete medical Record
☐ Billing Records
☐ Radiology film/tracing/media
☐ Other/Outside (please specify): _____
☐ Psychotherapy notes There are no psychotherapy notes in inpatient settings, nor most office visits. A separate form requesting only psychotherapy notes must be completed if these notes are requested.)

Covering the period of health care from:

☐ Specific date(s): _____ to _____ OR ☐ All dates of encounters/visits.

Purpose for requesting information:

☐ Continuing Care ☐ Personal
☐ Insurance ☐ Legal
☐ Other: _____

How are we to send the requested information:

Records will be released electronically rather than on paper if possible.
Fee may apply for records in paper format.

☐ Secure E-Mail ☐ Fax (to health care provider only)
☐ CD (electronic format) ☐ Paper

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- Medical record information may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse. I authorize the release of these records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to Health Information Management. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____ If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure on information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that I have a right to receive a signed copy of this authorization.

Patient/Authorized Representative Signature* _____ **Date** _____ **Time** _____

Printed Name of Authorized Representative: _____ **Relationship to Patient:** _____

*If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Driver's License or Photo ID *(required when records are picked up)* Driver's License State: _____ Number: _____

Witness Signature _____ Date _____ Time _____

Send completed form to: The University of Kansas Health System – Health Information Management
4000 Cambridge St, MS 9345 Kansas City, KS 66160
Attach Signed Form to E-Mail: ROI@kumc.edu or Fax: 913-588-2495
https://www.kansashealthsystem.com/patient-visitor/patient-guide/medical-records

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