"Compassionate care for your whole family."

SPRING HILL FAMILY MEDICINE

913.592.2720 • F 913.592.2725 • www.springhillfamilymedicine.com

Jerad Widman, MD

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO BE SENT TO OUR OFFICE

Patient Name:		
Address:		
Phone Number:	Date of Birth:	SSN:

I authorize _____

Dr's name you are requesting records from

_____

Office address you are requesting records from

_____

City **State** **Zip**

_____

Dr's office phone number **Dr's office fax number**

To release medical information concerning the above named patient to

Spring Hill Family Medicine
22450 S. Harrison St., Ste. 100
Spring Hill, KS 66083

(913) 592-2720 (phone)
(913) 592-2725 (fax)

☐ **Please fax records**
☐ Please mail records

Specific description of the information that may be used or disclosed which includes date(s):

_____ Complete medical records (This will include information relating to substance abuse, mental health, and HIV unless excluded by initialing below).

_____ Partial medical records (Specify what part(s) and the date(s) to be released: (For example – Lab reports, x-rays, immunization records) _____

I do not authorize the release of any information regarding: (Initial the corresponding line)

Substance Abuse: _____ Mental Health Info: _____ HIV Info: _____

Specific description of how the information will be used: (Fees may be required to transfer records)

I understand that this authorization will expire one year from the date of the signature except as specified: _____.

1. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Spring Hill Family Medicine or the above listed entity in writing.
2. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
3. I may inspect or copy any information used or disclosed under this agreement (copying fees may apply).
4. I understand that Spring Hill Family Medicine will not disclose the above information without my written approval.
5. I understand any charges associated with the copying of my records will be my responsibility.

X _____ _____

Signature of Patient or Patient's Representative — Relationship to Patient

_____ _____

Print Name of Patient or Patient's Representative — Date