CFC Medical Records Release

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Name _____

Address _____
Street City State ZIP

Home/Cell phone _____ **Work phone** _____

Date of birth _____

Reason for Request: _____

Please transfer my medical records* as follows:

From: Compassionate Family Care LLC
Laura N. Ray, MD
15900 College Blvd, Suite 100
Lenexa, KS 66219
Phone: (913) 744-4300 Fax: (913) 859-9134

To: _____
_____
_____
_____
_____

***Records to be released**:
☐ Annual exam and Pap smear / Prostate
☐ Labs/Xray
☐ Birth control
☐ Abortion care
☐ Past 2 years medical records
☐ Other _____

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.
Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.
_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STI test results and/or treatment

**THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF SIGNATURE EXCEPT AS SPECIFIED: _____(SPECIFY 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 may be re-disclosed.

Signature of Patient or Legal Guardian: _____ Date: _____
Electronic Signature

Relationship if not the Patient: _____

Signature of Witness: _____ Date: _____