Holy Family Medical Associates
144 S. Hillside Street
Wichita, KS 67211
Phone: (316) 682-9900
Fax: (316) 682-0311

Medical Record Release Authorization

Patient Name_____ SS#_____

Date of Birth_____ Home Phone_____ Cell_____

Address_____ City/State/Zip_____

Email address:_____

I hereby authorize records FROM: **OR** **To be released TO:**

Name_____ Name_____

Address_____ Address_____

City/State/Zip_____ City/State/Zip_____

Phone number_____ Phone number_____

Fax number_____ Fax number_____

RECORDS ARE NEEDED FOR THE PURPOSE OF:

☐ Litigation ☐ Insurance ☐ Disability ☐ Work Comp ☐ Auto Accident ☐ Transfer of Care ☐ Self
Other_____

RECORDS REQUESTED:

☐ Office Visit Notes ☐ Immunizations ☐ Lab/Pathology Reports
☐ Cardiology/EKG Reports ☐ X-ray and Imaging Reports ☐ Other_____
☐ Past two years records for continuity of care ☐ Complete health record without limitations (copy fees may apply)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization that was originally authorized to disclose my health information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date, this authorization will expire in one (1) year from the signature date.

I understand and agree to pay for the cost of copying the requested records. 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 I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by deferral confidentiality rules. If I have questions about disclosure of my health information, I can contact the clinics privacy officer.

_____ _____
Signature of Patient, Parent or Legal Representative Date

_____ _____
Relationship to Patient Date