THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160	Do not write in this box 	HIM Office Only Medical Record #: ____________________ Date Received in HIM: ____________________

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 Hospital Authority, The University of Kansas Physicians & KU Health Partners, Inc.)

Patient Last Name: ______________________ **First Name**: __________________ **MI**: ______ **Date of Birth**: __________
Patient Name at time of treatment (if different): Last Name: ____________________ **First Name**: ____________________ **MI** ___
Address: ____ **City**: ____________ **State**: _____ **Zip Code**: _________
E-Mail Address: (Optional) ____ **Phone**: ____________________

I request my protected health information (PHI) from:

☐ The University of Kansas Hospital and or The University of Kansas Physicians
☐ The University of Kansas Cancer Center
☐ Indian Creek Campus
☐ KU MedWest Ambulatory Surgery Center ☐ KU MedWest (Other) __________
☐ KU HealthPartners Audiology
☐ Other: ____

Clinics: Specify Clinic Name
____
____
____
____
____

I request my protected health information (PHI) to be released to *

Name ____ Phone: ____________________
Address: ____
City/State ____________________ Zip Code ________ Fax Number: (Health Care Provider Only) ____________________

**If records are going to be picked up – the name of individual picking up the records should be listed*

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

☐ Emergency Department Record
☐ Pertinent Documentation (key physician notes/test results – last two years only unless otherwise specified)
☐ Complete Record (Last two years only unless otherwise specified)
(Does not include Billing, Imaging CD/Films, or outside records unless otherwise specified)
☐ Lab Reports ☐ Radiology/Imaging Reports ☐ Discharge Summary ☐ Billing Records
☐ Outside Records (Specify location): ____
☐ Other (please specify): ____

Covering the period of health care from:
Specific Dates: ______________________ **to** ______________________ **OR: Past Year** ☐ **Past Two Years** ☐

Purpose for requesting information:

☐ Continuing Care ☐ Personal
☐ Insurance/Disability ☐ Legal
☐ Other: ______________________________

How are we to send the requested information:
(Paper will be mailed unless otherwise specified)

☐ Paper ☐ Fax (to health care provider only)
☐ Secure E-Mail ☐ CD (electronic format)
☐ Pick-Up at Hospital (B430) ☐ Pick-Up at 5799 Broadmoor Suite 200

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. See instructions for more information.**
- PHI 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.

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.

Drivers License or Photo ID *(required when records are picked up)* Drivers License State: __________ Number: ____________________
Witness Signature ____ **Date** __________ **Time** ________

Send completed form to: The University of Kansas Hospital – Health Information Management
5799 Broadmoor, Suite 200, Mission, Kansas 66202
Phone: 913-588-2454 Fax: 913-588-2495 Attach Signed Authorization to E-Mail: ROI@kumc.edu

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The University of Kansas Hospital

Instructions for completing the Authorization for the Release of Confidential Information

1. Complete the first section with current patient name, and patient name at time of treatment if different, date of birth, current address, current e-mail address and day time telephone number.

2. **I request my protected health information (PHI) from:** Indicate where you received your patient care (from The University of Kansas Hospital; The University of Kansas Physician Clinic; Cancer Center; Indian Creek Campus, KU MedWest etc.). If records are requested from a specific physician clinic, please list the clinic name(s).

3. **I request my protected health information (PHI) to be released to:** Complete the name of the individual/company where you would like us to send the copies to. If the copies are for you, state "Self" in the name field. Also complete the contact information including phone, address and fax number if the copies are to be sent to another health care provider. If the records are going to be picked up, the name of the individual picking up the records should be listed.

4. **I request the following PHI to be released from my medical record(s):** Mark the documents that you are requesting. An abstract or pertinent documentation includes key physician notes and test results. This is what most other health care providers like to have. When selecting either pertinent documentation or complete record, please note that we will send only the last two years unless otherwise specified. Test results when marked individually are generally for specific dates of service as indicated in the next section.
   - If billing records only are being requested, these are NOT kept in the Health Information Management Department. Mail the authorization form to Patient Financial Services at 2330 Shawnee Mission Parkway, Suite 200, Westwood, Kansas 66205. You may call Patient Financial Services at 913-945-5286.
   - For billing records provided at The University of Kansas Physicians, please mail the authorization to UKP at P. O. Box 411851, Kansas City, Missouri 64141-1851. You may also call McKesson at 1-877-729-5874.
   - If you are requesting Radiology/Imaging Film/CD, these also are NOT kept in the Health Information Management Department. If that is all that is being requested, mail the authorization form to Imaging Center, 2015 W. 39th Street, Kansas City, Kansas 66160. You can fax to the Imaging Center at 913-588-6899. Their telephone number is 913-588-6812.

5. **Covering the period of health care from:** Please list specific dates; past year or past two years. If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.

6. **Purpose for requesting information:** Please mark if the records are for continuing care, personal, insurance or legal.

7. **Is there a charge for copies of my medical records?** If the request is for continuing care and we are asked to send the records directly to your health care provider, there will be no charge. In all other cases, there is a charge for copies of medical records. Payment is expected when records are released. As of April 2014, the fees are as follows: $23.38 plus .54 per page. There is an additional charge of $15.26 if the record is stored offsite. For records produced on CD or sent via secure e-mail, the fee is also $23.38 plus .54 per page, but there is a maximum charge of $102.46.

8. **How information is to be received (if not marked, mail is the default):** Paper records or CDs will be mailed to the address provided. Records can be sent via secure e-mail if this is requested. Records will be faxed only to another health care provider. Records can be picked up at between the hours of 8 a.m. – 4:30 p.m. Monday through Friday at either of two locations: The University of Kansas Hospital – Basement Level - Room B 430; or 5799 Broadmoor, Suite 200. Please call in advance of picking up records. The number to call is 913-588-2454. *When picking up records in person, a photo ID will be required as well as a copy of any legal papers (power of attorney, executor of estate, proof of custody, etc).*

9. **Patient/Authorized Representative Signature:** This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate etc.) sign and date the form. Please provide printed name and relationship to the patient. Supporting legal documentation must accompany this authorization form when signed by an authorized representative.

10. **Drivers License or Photo ID:** This will be required when picking up records at either of our locations as listed above.

11. **Witness Signature:** A witness must sign and date the form in the event that the patient can only make an X or is unable to sign.

Please call Health Information Management if you have any further questions. 913-588-2454