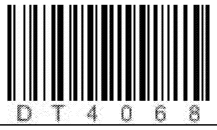
THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160	Do not write in this box  DT4068	UKHS Office Only Medical Record #: _____ Date Received in HIM: _____

PATIENT/PERSONAL REPRESENTATIVE REQUEST FOR HEALTH INFORMATION

(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:** _____
Phone: _____

I request the following information 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)
☐ Lab Reports ☐ Radiology/Imaging Reports ☐ Discharge Summary ☐ Operative/Pathology Reports
☐ Immunizations
☐ Outside Records (Specify location): _____
☐ Mental Health Records ☐ Psychotherapy Notes (separate request required)
☐ Other (please specify): (The above requested items do not include Billing, Imaging CD/Films, or records from outside providers unless otherwise specified.)

_____

Specific Treatment Dates: _____ **to** _____
OR: Past Year ☐ **Past Two Years** ☐ (Only the last two years will be released unless otherwise specified.)

Requested record format: (Records will be released electronically rather than on paper unless otherwise specified.)
☐ MyChart ☐ Secure (Encrypted) E-Mail ☐ Unsecure (Unencrypted) E-Mail ☐ CD (electronic format) ☐ Paper copy

Delivery method:
☐ Electronically (MyChart, Secure or Unsecure E-Mail) Email address: _____
☐ US Postal Service Mail

☐ Pick-Up at*	☐ Pick-Up at*	☐ Pick-up at*	☐ Pick-up at*
Hospital Main Campus Suite B430	5799 Broadmoor Suite 200, Mission KS 66202	Marillac 8000 W 127th Street Overland Park, KS 66213	Other Location _____ _____

***If records are going to be picked up by someone other than the patient, the name of individual picking up the records should be listed here. I request my medical record information to be released to:**
Name _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____

I understand that:

- **Requests for copies of medical records and/or non-document material may be subject to copying fees. See instructions on reverse for more information.**
- Medical record information may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- Information delivered through email is inherently unsecure unless it is fully encrypted. Requesting that my records are sent to an unsecured email address is not a secure delivery method and there is risk that my health information may be intercepted and/or viewed by unauthorized persons. The University of Kansas Hospital and its affiliates are not responsible for a third party's unauthorized access to my personal health information delivered in this format or any risks (e.g., virus) potentially introduced to my computer/device when receiving personal health information though unsecure email.

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 form.

Department Use Only:
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 Hospital – Health Information Management
5799 Broadmoor, Suite 200,
Mission, Kansas 66202
Phone: 913-588-2454 **Fax: 913-588-2495** **Attach Signed Form to E-Mail: ROI@kumc.edu**

MRD-1119
Rev 10/16

PATIENT/PERSONAL REPRESENTATIVE REQUEST FOR HEALTH INFORMATION

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

The University of Kansas Hospital

Instructions for completing the Patient/Personal Representative Request for Health Information:

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

2. **I request the following medical record information to be released:** Mark the documents that you are requesting. Pertinent documentation includes key physician notes and test results. 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 request 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 request form 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.

4. **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.

5. **Is there a charge for copies of my medical records?** This depends on the format of the record and delivery method.
   A. Any record sent to you electronically via MyChart, CD, or secure email is provided at no charge.
   B. For medical records maintained in electronic format and provided on paper, the first 100 pages are provided at no charge. When the number of pages exceeds 100 pages, there is a total fee of $6.50.
   C. For medical records maintained in paper format and provided on paper, the first 100 pages are provided at no charge. When the number of pages exceeds 100 pages, there will be a fee that corresponds to our cost of providing the requested copies in paper format which is $0.10 per page beginning with page 101.
   D. If records are mailed, actual postage will be charged.

6. **How are we to send the requested information (Records will be released electronically rather than on paper unless otherwise specified).** Electronic format would include releasing directly to MyChart, secure e-mail, or CD.

7. **Release method:** Records will be sent via secure e-mail or directly to MyChart if this is requested. CDs or paper records will be mailed to the address provided. CDs or paper records can also be picked up between the hours of 8 am – 4:30 pm Monday through Friday at The University of Kansas Hospital – Basement Level - Suite B430; or 5799 Broadmoor, Suite 200. Marillac medical records may be picked up at: 8000 W. 127th Street, Overland Park, Kansas. Please call in advance of picking up records. The number to call is 913-588-2454; or 913-951-4457 for the Marillac location. *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).*

8. **If records are going to be picked up by someone other than the patient, the name of the individual picking up the records should be listed:** Please complete the name, phone number, address of the individual who will be picking up your medical records. A driver's license or photo ID will be required to be shown at the time of picking up the medical records.

9. **Patient/Personal 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 personal representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate, etc.), the Personal Representative should 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 a personal representative.

10. **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

PATIENT/PERSONAL REPRESENTATIVE REQUEST FOR HEALTH INFORMATION