THE UNIVERSITY OF KANSAS HEALTH SYSTEM
4000 Cambridge Street
Kansas City, Kansas 66160

Do not write in this box
DT4068
Request for Records

Medical Record #: _____

Account #: _____

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 records to be sent to *:
Name _____ Phone: _____
Address: _____
City/State _____ Zip Code _____ Fax Number: (Health Care Provider Only) _____
E-Mail Address: _____
* *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):
Specific Treatment Dates: _____ **to** _____
OR: ☐ Past Year ☐ **Past Two Years** (Only the last two years will be released unless otherwise specified.)
☐ *****Abstract (Hospital Summary which includes physician reports, lab, radiology and other test results)
☐ Emergency Room Record
☐ Clinic records – specify clinic or physician _____
☐ Lab Reports ☐ Radiology/Imaging Reports ☐ Discharge Summary ☐ Operative/Pathology Reports ☐ Immunizations
☐ Mental Health Records – Includes Inpatient and/or ambulatory office visit notes.
☐ Complete medical Record **(Last two years only unless otherwise specified.)**
☐ Billing Records (forward to Patient Financial Services)
☐ Radiology film/tracing/media (forward to Radiology Imaging Center)
☐ Other (please specify): There are no psychotherapy notes in inpatient settings, nor most office visits. A separate form requesting only psychotherapy notes must be completed if these notes are requested.) _____

Purpose for requesting information:

☐ Continuing Care ☐ Personal
☐ Insurance ☐ Legal
☐ Other: _____

How are we to send the requested information:
Records will be released electronically rather than on paper if possible.

☐ Secure E-Mail ☐ Fax (to health care provider only)
☐ CD (electronic format) ☐ Paper

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.**
- Medical record information 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.
- I understand that I have a right to receive a signed copy of this authorization.

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.

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 Health System – Health Information Management
11300 Corporate Ave, Suite 345 Lenexa, KS 66219
Attach Signed Form to E-Mail: ROI@kumc.edu or Fax: 913-588-2495
https://www.kansashealthsystem.com/patient-visitor/patient-guide/medical-records

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160	Do not write in this box	**Medical Record #:** _____ **Account #:** _____

The University of Kansas Health System

Instructions for completing the Authorization for the Release of Confidential Information

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

2. **I request my records to be sent 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.

3. **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.
   - Billing records are NOT kept in the Health Information Management Department. If you are requesting billing records only, mail this form to Patient Financial Services at 11300 Corporate Ave, Suite 260 Lenexa, KS 66219. You may call Patient Financial Services at 913-588-5820.
   - Radiology Images (Films) are NOT kept in the Health Information Management Department. If you are requesting radiology images (film) only, mail this 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. **Specific treatment dates:** 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. **Purpose for requesting information:** Please mark if the records are for continuing care, personal, insurance or legal.

6. **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 requested. Records will be faxed only to another health care provider. Records can be picked up between the hours of 8 a.m. – 4:30 p.m. Monday through Friday at The University of Kansas Health System – Basement Level - Room B 430. Please call Health Information Management at 913-588-2454 in advance of picking up records. *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.).*

7. **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.

8. **Driver's License or Photo ID:** This will be required when picking up records at either of our locations as listed above.

9. **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 email or call Health Information Management at 913-588-2454 if you have any further questions.

The University of Kansas Health System – Health Information Management
11300 Corporate Ave, Suite 345 Lenexa, KS 66219
Attach Signed Form to E-Mail: ROI@kumc.edu or Fax: 913-588-2495
https://www.kansashealthsystem.com/patient-visitor/patient-guide/medical-records