THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160	**Do not write in this box** (Barcode: DT4068) Request for Records	**TUKHS Office Only** **Medical Record #:** _____ **Date Received:**_____

Radiology Imaging Center

AUTHORIZATION TO RELEASE IMAGES (FILMS) FOR CONTINUED HEALTHCARE

Today's Date _____

Unless otherwise specified in writing by the patient, this authorization will expire within 1 year of the date above.

Patient Last Name: _____First Name: _____Middle Name: _____

Patient's Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

E-Mail Address: (Optional)_____ Phone: _____

Date needed by: _____

Films to be ☐ Sent or ☐ Hand Carried to:

_____

_____

_____

Phone of Health Care Provider where images are going: _____

Exams needed: _____

_____

I understand that my Personal Health Information will only be used as described in this authorization. I am also aware that if I choose to share the information defined in this authorization with anyone not directly involved in the use or disclosure described above, HIPAA will no longer protect this information. In addition, I understand that if my personal health information is disclosed to someone who is not required to comply with privacy protections under the HIPAA, then such information might be re-disclosed and will no longer be protected.

PATIENT'S SIGNATURE: _____

Send completed form to: The University of Kansas Health System
Department of Radiology-RIC
4000 Cambridge St., Suite BH 2360
Kansas City, KS 66160
Phone: 913-588-6812
Fax: 913-588-6899

Department Use Only:
Driver's License or Photo ID *(required when records are picked up)*
Driver's License State:_____ **Number:**_____
Witness Signature_____**Date**_____**Time**_____