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

Do not write in this box

DT4068
Request for Records

TUKHS Office Only

Medical Record #: _____

Date Received in HIM: _____

Patient-Directed Request for Health Information

Applies to The University of Kansas Health System- Kansas City and Great Bend Campus

Patient Last Name: _____ First Name: _____ Date of Birth: ___/___/___
Address: _____ City: _____ State: _____ Zip Code: _____
E-Mail Address: (Optional) _____ Phone: _____

What records do you want? (Check appropriate boxes below):

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.)
_____

I request my records to be sent to:

☐ Self /Family ☐ Health Care Provider ☐ Insurance ☐ School ☐ Employer ☐ Attorney
Name: _____ Phone: _____
Address: _____
City/State: _____ Zip Code: _____ Fax Number: (Health Care Provider Only) _____
E-Mail Address (if applicable): _____

How would you like your records delivered? (Records will be released electronically rather than on paper unless otherwise specified.)

Electronic: ☐ MyChart Portal ☐ **Secure (Encrypted) E-mail ☐ **Unsecure (Unencrypted) E-mail ☐ CD ☐ Fax (to health care Provider only)
Paper: ☐ Mail ☐ *In-Person Pickup at Kansas City Main Campus, Suite B430 ☐ Great Bend Campus

***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.**
- 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.
- ****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 Health System and its affiliates, including but not limited to The University of Kansas Medical Center, 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 through unsecure email.**
- 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 form.

Send completed form to: The University of Kansas Health System – Health Information Management
4000 Cambridge St, MS 9345 Kansas City, KS 66160
Attach Signed Form to E-Mail: ROI@kumc.edu or Fax: 913-588-2495
https://www.kansashealthsystem.com/patient-visitor/patient-guide/medical-records

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

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The University of Kansas Health System

Instructions for completing the Patient-Directed Request for Health Information:

1. Complete the first section with your current name, date of birth, current address, current e-mail address and daytime telephone number.

2. 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.

3. What records do you want? Mark the documents that you are requesting. 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 are NOT kept in the Health Information Management Department. If you are requesting radiology images (films) 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. For Images from the Great Bend Campus, please call 620-282-9865 or you can fax this form to 620-792-7315.

4. I request my records to be sent to: Check the appropriate box. If records are being sent to someone other than the patient, then specify whom the records should be released.

5. How would you like your records delivered? 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. CDs or paper records will be mailed to the address provided.
6. 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.

7. 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.

8. 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.

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https://www.kansashealthsystem.com/patient-visitor/patient-guide/medical-records