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 Health System- Kansas City and Great Bend Campus

Patient Last Name: _____**First Name:** _____**MI**: _____**Date of Birth**: ____/____/____
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: _____

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

Campus: ☐ Kansas City & surrounding areas ☐ Great Bend ☐ St. Rose ☐ Central KS Family Practice

☐ Pertinent (Inpatient 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
☐ Billing Records
☐ Radiology film/tracing/media
☐ Other (please specify): _____
☐ Psychotherapy notes 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.)

Covering the period of health care from:

☐ Specific date(s): _____ to_____ OR ☐ All dates of encounters/visits.

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.
Fee may apply for records in paper format.

☐ 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
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

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 daytime 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 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. 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.

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
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

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION