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

Do not write in this box

DT4068
Request for Records

HIM Office Only

Medical Record #: _____

Date Received in HIM: _____

Enter Death Date in O2: _____

ACCESS TO MEDICAL OR FINANCIAL RECORDS FOR DECEASED PATIENT WITH NO EXECUTOR

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: _____

Date of Death: _____ SSN: _____

I request the following PHI to be released from the deceased patient's 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, or 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_____

Purpose for requesting information:

☐ Patient's Financial and Personal Affairs

How are we to send the requested information:

Records will be released electronically rather than on paper if possible.
There may be a fee for paper format.

☐ Secure E-Mail ☐ Fax (to health care provider only)
☐ CD (electronic format) ☐ Paper ☐ Pick-Up
☐ Kansas City Main Campus Suite B430 ☐ Great Bend Campus

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. See instructions for more information.**
- PHI 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.
- Federal privacy regulations ("HIPAA") and State laws require TUKHS to preserve the confidentiality of information contained in its patient records, including its deceased patient records. I understand that TUKHS may not disclose the Patient's records to me, unless the disclosure complies with HIPAA and State law.
- With respect to the Patient, I understand that a personal representative can receive the Patient's records and can authorize TUKHS's disclosure of the Patient's records for purposes not otherwise permitted by HIPAA. A "personal representative" (as defined by HIPAA) is an executor, administrator, or other person who has authority under applicable State or other law to act on behalf of a decedent or a decedent's estate.
- Unfortunately, at the time of death, the Patient did not name a personal representative, nor did the Patient have sufficient assets at the time of death to require the opening of a formal probate estate to name an executor or administrator. Notwithstanding the fact that there is no personal representative, executor or administrator named, based upon my personal relationship to the Patient (which may have involved participation in the Patient's health care or payment for care prior to the Patient's death) and, with notice I have provided to those known living family members of the Patient, I have assumed the responsibility to address the remaining personal and financial affairs of the Patient.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Authorized Representative Signature _____ Date _____ Time _____

Printed Name of Authorized Representative: _____ Relationship to Patient: _____

Authorized Representative Address: _____ City: _____ State: _____ Zip Code: _____

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

Authorized Representative Phone Number(s): _____

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 Authorization to E-Mail: ROI@kumc.edu or Fax: 913-588-2495
https://www.kansashealthsystem.com/patient-visitor/patient-guide/medical-records

THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160	**Do not write in this box**	**HIM Office Only**

ACCESS TO MEDICAL OR FINANCIAL RECORDS FOR DECEASED PATIENT WITH NO EXECUTOR

Instructions for completing Access to Medical or Financial Records for Deceased Patient with No Executor

1. Complete the first section with current patient name, and patient name at time of treatment if different, date of birth, and date of death.

2. I request the following PHI to be released from the deceased patient's medical record: 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.

3. 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.

4. Purpose for requesting information: If you are requesting records for other purposes other than settling patient's financial and personal affairs, then please contact the HIM Department at ROI@kumc.edu or 913-588-2454.

5. How information is to be received (if not marked, secure mail is the default): Paper records or CDs will be mailed to the address provided. Records can be sent via secure e-mail if this is requested.

6. Authorized Representative Signature: This form should be signed by the authorized representative.

7. Authorized Representative Contact Information: Please provide a current address, phone and email address for questions.

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.

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