



Do not write in this box



DT4068

Authorization to Release Protected Health Information

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

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):

- Checkboxes for: Pertinent (Inpatient Summary...), Emergency Room Record, Clinic records, Lab Reports, Radiology/Imaging Reports, Discharge Summary, Operative/Pathology Reports, Immunizations, Mental Health Records, Complete medical Record, Billing Records, Radiology film/tracing/media, Addictions Clinic, Other/Outside (please specify):

Covering the period of health care from:

Specific date(s): \_\_\_\_\_ to \_\_\_\_\_

Purpose for requesting information:

- Checkbox: 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. Checkboxes: Secure E-Mail, Fax, CD, Paper, In Person Pick-Up

By signing this authorization form, I understand that:

- Requests for copies of medical records... PHI may include records relating to mental health care... Federal privacy regulations... With respect to the Patient... Unfortunately, at the time of death... Any disclosure of information carries with it the potential for unauthorized re-disclosure... Secure email uses a link to the MyChart application...

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): \_\_\_\_\_

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



## 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. 39<sup>th</sup> 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](mailto: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](mailto:ROI@kumc.edu) or Fax: 913-588-2495

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