ENT Associates of Greater Kansas City

Authorization to Release Records

Patient Name: _____ Date of Birth: _____ Phone Number: _____

I hereby authorize you to use or disclose the specific information only for the purposes and parties described below.

I would like for **ENT Associates of Greater Kansas City** to release my records ***to*** the following via ☐ Fax ☐ Mail ☐ CD ☐ Portal

Name: _____ Address: _____

Phone #: _____ Fax #: _____ City, State, Zip _____

I would like for **ENT Associates of Greater Kansas City** to ***obtain*** my records ***from*** the following:

Name: _____ Address: _____

Phone #: _____ Fax #: _____ City, State, Zip _____

This information is being requested for the following purposes:

_____

I understand that:

* I may revoke this authorization in writing by contacting:

ENT Associates of Greater Kansas City
Attn: HIPAA Privacy Officer
3340 NE Ralph Powell Road, Suite B
Lee's Summit, MO 64064
Phone: 816-875-2595 Fax: 816-875-2597

* Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
* ENT Associates of Greater Kansas City will not charge for records sent to another physician.
* I understand I will be charged a fee for records requested for my own use.
* I understand there will be an additional fee for requested records on a CD-ROM.
* This authorization expires one year from the date it was signed.

Patient Signature: _____ Date: _____

**If the Patient cannot act for themselves,a legal guardian or power of attorney needs to sign.*

Legal Representative's Name: _____ Date: _____

Legal Representative's Signature: _____ Relationship to patient: _____

FOR OFFICE USE ONLY

Request received by: _____ Date Received: _____

Records sent by: _____ Date Released: _____

Scan into EMR: Admin Actions
Label: Release of Information

Revision Date: 08-26-13