Johnson County MED-ACT

Medical Records Release of Information

PROTECTED HEALTH INFORMATION - CONFIDENTIAL

Please complete the following information for the patient whose medical record is being requested. Return the completed request with a Notarized signature and appropriate fee to Patient Services Representative, Johnson County Med-Act, 11811 S. Sunset Dr. Suite 1100, Olathe, KS. 66061, who will validate and process the request records, Phone **913-715-1950**, Secure Fax No.: **913-715-1989**

Patient's Name	SSN	Date of Birth
Patient's Address	City	State & Zip code
Patient's Telephone No. & area code	Legal guardian (if any)	Date of Request

I authorize the disclosure of my personal health information as listed below. I understand this authorization is voluntary and made to confirm my directions. I hereby give my permission to Johnson County MED-ACT to disclose my personal health information in the manner described herein.

- ☐ All Medical Records
- ☐ Only Medical Records from this date ____ / ____ / ____
- ☐ All Ambulance Fees or Statements
- ☐ Only Fees or statements from this date ____ / ____ / ____
- ☐ Other: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health matters, and information about drug and alcohol abuse.

RESTRICTIONS: Only medical records that have originated through this health care provider will be photocopied. This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authorization. This information may be disclosed to and used by the following individual or organization:

Name of Patient OR Person Requesting Release and Representative Capacity	Release to (company or firm name)	Phone No. / FAX No.
Address	City.	State & Zip code

Please state the reason or purpose for this release. _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Med-Act's privacy officer at 913-715-1950.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. Sign, date and notarize this form. Send or FAX to Johnson County MED-ACT: Secure Fax No.: 913-715-1989. Mailing found address below.

Signature of Patient **OR** Person Requesting Release and Representative Capacity	Date
Name of Business if not the patient	

Notary Stamp Here

Notary Signature	My Appointment Expires Date Above	Signature Date