REQUEST FOR RELEASE OF MEDICAL RECORDS

SOUTHEAST KANSAS ORTHOPEDIC CLINIC
1902 S. HWY 59, BLDG D
PO BOX 678
PARSONS, KS 67357
PHONE: (620) 421-0881 FAX: (620) 421-8391
KEVIN MOSIER, MD BRAD MEISTER, MD BRANDON MORRIS, MD

Dates of Treatment and Records Released

From: _____ to _____

☐ History and physical ☐ X-ray reports/disc ☐ Office notes
☐ Discharge summaries ☐ Lab reports ☐ Consultations
☐ Operative/procedure notes ☐ Emergency services ☐ OTHER_____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

YOU AUTHORIZE: Please check box next to facility/provider authorized to disclose (provide) information:
☐ Southeast Kansas Orthopedic Clinic
☐ Other facility/provider: _____

TO DISCLOSE TO: (Where you want records to go)
Name/Organization: _____
Address: _____
City/State/Zip: _____

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment may be released. I also understand that if I do not ask for my legal medical record or specify the records I want, the Medical Information Services department will send an abstract of my legal medical record. This authorization expires automatically (365) days from the date of my signature or as otherwise specified by date, event or condition.
This information has been disclosed to you from records whose confidentiality is protected by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

⇒**Printed Name of Patient/Legal Representative**: _____

⇒**Signature of Patient/Legal Rep**.:_____**Date**: _____

Relationship to Patient: _____