



TRUMAN MEDICAL CENTER
Lakewood

Better. For Everyone.

TMC MR#: _____

Date: _____

Truman Medical Center Lakewood | 7900 Lee's Summit Road | Kansas City, MO 64139

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

Requests for Records may take approximately 10-14 days to process

Patient Name: _____

Date of Birth: _____ SSN#: _____

I, _____ hereby authorize Truman Medical Centers to release/disclose
the records of the above patient to:

Requestor _____

Street Address _____

City _____ State _____ Zip _____ Telephone _____

The following medical records and information (specify dates of service and information requesting):

This information is released for the following purpose and that purpose only. No other use or further disclosure of information permitted.

Purpose: _____

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the contact office below, except to the extent that action has been taken in reliance thereon. This consent, unless expressly revoked in writing earlier, shall expire within six months of the date signed if I have not provided an expiration date or if the following occurs: _____

This information will be released only to the person or agency named above.

Contact Office: Truman Medical Centers Health Information Management
7900 Lee's Summit Road, Kansas City, MO 64139
Phone: 816-404-8480 Fax: 816-404-8483

READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of any medical information requested to the agency or person specified above. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization I am allowing the release of any drug and/or alcohol information to the agency or person specified above. Additionally, I understand that information released may include Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus).

Signature of Patient _____

Date of Consent _____

Signature of Legally Responsible Party _____

Date of Consent _____

Specify Relationship to Patient _____

Signature of Witness _____

Date _____

PROHIBITION ON DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. You have the right to view and receive copies of certain portions of your medical & financial records kept by Truman Medical Centers or our business associates. You may not view or receive copies of any psychotherapy notes, any information that will be used in a civil, criminal or administrative action or proceeding, information restricted under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records.