SIGNATURE
MEDICAL GROUP
PHYSICIANS MAKING A DIFFERENCE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
SIGNATURE MEDICAL GROUP OF KC, P.A.

(816) 478-0220 Fax (816) 795-3456

Patient's Full Name (Print):	
Former Name(s) (where applicable)	
SSN:	Date of Birth:
Phone:	Fax:

I, or my personal representative, hereby authorize Signature Medical Group of KC, P.A. (Signature) to use or disclose protected health information regarding my care and treatment. I understand that:

1. Information relating to **ALCOHOL/DRUG ABUSE, MENTAL HEALTH TREATMENT, GENETIC TESTING**, and/or **CONFIDENTIAL HIV-RELATED INFORMATION** will not be disclosed unless I specifically authorize such disclosure by placing my initials in the appropriate space(s) in item 8(b).

2. Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV-related information, the recipient is prohibited from re-disclosing the information without authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who may receive or use my HIV-related information without authorization.

3. I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed in item 5 below, except to the extent Signature has already relied upon this authorization.

4. Signing this authorization is voluntary. Signature may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

5. Provider releasing this information (one provider per form): Name: ______

Address: ______ Phone: ______ Fax: ______

6. Purpose for Release of information: ☐ At my request ☐ Continuity of Care ☐ Other: ______

7. Person(s) to receive this information: ☐ Send to Name: ______

Address: ______ Phone: ______ Fax: ______

8. Description of information being release : (a) Date(s) of service (required, list all dates):

I would like (choose one) ☐ Last (5) years of Medical Records ☐ Obstetric Records
☐ Laboratory Reports ☐ Operative Notes
☐ Other (specify)

(b.) Include information relating to (*initial* beside each applicable category): ☐ Alcohol/Drug Treatment ______
☐ Mental Health Treatment ______ ☐ Genetic Testing Information ______
☐ Psychotherapy Notes (complete a separate authorization form for these notes) ______ ☐ HIV-related Information ______

9. Date or event on which this authorization will end: ☐ One-Time Request ☐ Specific Event or End Date ______

10. Signature: By signing below I acknowledge that I have read and agree with all of the above.

Signature: ______ Date: ____ / ____ / ____

Print name of personal representative if signing for patient and specify authority: ______

(supporting documentation required): ☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Administrator/Executor ☐ Other ______

THE PATIENT OR PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM UPON SIGNING