

Patient Authorization for Disclosure/Release of Medical Information

Patient Name: _____ DOB: _____

Address: _____

Account Number: _____

I request that communication regarding my protected health information that is provided to me, other than verbally and in person, be provided to me by calling the information to:

Home Phone: _____

Yes, appointment/confirmation/reschedule information can be left at this number.

No, appointment/confirmation/reschedule information cannot be left at this number.

Yes, test results/info for callback can be left at this number.

No, test results/info for callback cannot be left at this number.

Work Phone: _____

Yes, appointment/confirmation/reschedule information can be left at this number.

No, appointment/confirmation/reschedule information cannot be left at this number.

Yes, test results/info for callback can be left at this number.

No, test results/info for callback cannot be left at this number.

Cell Phone: _____

Yes, appointment/confirmation/reschedule information can be left at this number.

No, appointment/confirmation/reschedule information cannot be left at this number.

Yes, test results/info for callback can be left at this number.

No, test results/info for callback cannot be left at this number.

Or my information may be told to the following individuals:

Name: _____

Name: _____

DOB: _____

DOB: _____

Relationship: _____

Relationship: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

I understand that Kansas City Women’s Clinic may choose not to agree to such requests.

This request will be kept in place at all times until I revoke this request at any time in writing and submitting such request to Kansas City Women’s Clinic.

PLEASE SIGN AT THE "X"

X _____
Patient Signature

Date

Signature of Personal Representative of Patient

Description of Representative’s Authority to Act for Patient

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, _____, have received or been offered & declined a copy of Kansas City Women’s Clinic’s Notice of Privacy Practices.

PLEASE SIGN AT THE "X"

X _____
Patient Signature

Date

A COPY OF THE PRIVACY PRACTICES ARE AVAILABLE AT THE FRONT DESK