



KANSAS CITY WOMEN'S CLINIC

KCWC: A tradition of excellence since 1953

- Henry R. Bishop, M.D.
- Marty H. Thomas, M.D.
- Maggie H. Smith, M.D.
- Sandra R. Stites, M.D.
- J. Anthony Heit, M.D.
- Rhonda C. Wright, M.D.
- Renee M. Belieu, M.D.
- Erick Y. Arroyo, M.D.
- Paul S. Nguyen, M.D.
- Nancy M. McBride, M.D.
- Crystal M. Newby, M.D.
- Meghan A. Nichols, M.D.

- Samuel A. Montello, M.D. Emeritus
- Thomas H. McQuire, M.D. Emeritus
- Paul L. Riekhof, M.D. Emeritus
- Richard H. Sinclair, M.D. Emeritus

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ADMINISTRATIVE FAX: (913) 492-2874
MEDICAL RECORDS FAX: (913) 492-9025
WWW.KANSASCITYWOMENSCLINIC.COM

ACCOUNT # _____

CONSENT FOR KCWC TO RELEASE OF MEDICAL INFORMATION TO ANOTHER FACILITY OR TO THE PATIENT
(KCWC FAX: 913-492-9025)

I, _____ DOB: _____

authorize and request **KANSAS CITY WOMEN'S CLINIC PA** to release medical records to :

(Name of receiving organization/agency/person)

(Address, City, State, Zip Code)

I request the following information be released:

- ALL MY MEDICAL RECORDS. I understand that my medical records may include information regarding drug and alcohol abuse, HIV and AIDS information, mental health conditions and infection status.
- PARTIAL RECORDS (Please specify by date and type of visit)

REASON FOR RELEASE

I understand this consent may be revoked at any time except to the extent already acted upon. My written revocation must be submitted to **Kansas City Women's Clinic, P.A.**

I understand that **Kansas City Women's Clinic, P.A.** is unable to release copies of records that are in my medical chart from other physicians offices (these records need to be requested from the original physician).

I understand that in an effort to offset copying and mailing or faxing expenses, there is a \$15.00 charge for copies of my medical records, and \$5.00 charge for partial records, paid in advance by Credit Card (Visa, MasterCard or Discover), Debit Card or Cash. We recommend that you keep a copy for your own records. The charge for a second request within a two year period will be \$16.81 retrieval fee plus \$.56 a page.

I do not have to sign this authorization in order to receive treatment from **Kansas City Women's Clinic, P.A.**. In fact, I have the right to refuse to sign this authorization.

A photocopy of this consent shall be considered as effective and valid as the original.

This authorization will automatically expire one year from date of signature unless specified otherwise:

_____ (Specify date – not less than 30 days)

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

Signature of Patient (or Authorized Representative; what authority)

Date