



A/C # _____

Consent for Release of Medical Information

from an out side facility to KCWC.

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. McGuire, M.D. Emeritus
 Paul L. Riekhof, M.D. Emeritus
 Richard H. Sinclair, M.D. Emeritus

I, _____
(print name)

born _____, authorize and request
(date of birth)

PHYSICIAN

PHYSICIAN ADDRESS

to disclose to: Medical Record/Kansas City Women's Clinic/10600 Quivira, 3rd Floor, OP KS 66215

The following medical records: (Specifically describe the information to be released such as date(s) of service,

- All of my medical records except those relating to care and treatment for mental health Conditions, drug or alcohol abuse, or HIV testing, infection status or care and treatment for AIDS.
- All of my medical records including the following:
 - relating to care and treatment for mental health conditions
 - relating to care and treatment for drug or alcohol abuse
 - relating to HIV testing, infection status, or care and treatment for AIDS

10600 QUIVIRA ROAD, 3RD FLOOR
 OVERLAND PARK, KANSAS 66215-2309
 (913) 894-8500

12330 METCALF AVE., SUITE 420
 OVERLAND PARK, KANSAS 66213-1324
 (913) 696-1900

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

For the purpose of _____
(reason for disclosure)

I understand this consent may be revoked in writing at any time except to the extent already acted upon.
 My written revocation must be submitted to Kansas City Women's Clinic.
 This consent expires on: _____

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

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

Patient's name as known by provider medical records (Please Print)