NORTHLAND WOMEN'S HEALTH CARE, P.C.
OBSTETRICS / GYNECOLOGY
8600 NE 82nd St. • Kansas City, Missouri 64158
Phone: 816-741-9122 • Fax: 816-741-9665

AUTHORIZATION TO RELEASE HEALTH INFORMATION

* = required field

Please be aware that there is a charge per page of medical records given directly to the patient.
Please allow 5-10 days for records to be copied. Thank you.

PATIENT INFORMATION

Name of Patient * _____ Date of Birth * _____ Phone _____

Address _____ City _____ State _____ Zip _____

◯ **Release and Send my Medical Records TO – or –** ◯ **Obtain my Medical Records FROM**

Name _____ Choose one ◯ Physician ◯ Patient ◯ Attorney ◯ Insurance Company

Address City _____ State _____ Zip _____

Phone _____ Fax _____

This authorization is for the release of records pertaining to (check all that apply):

☐ Entire Record ☐ Office Visit Notes ☐ Care and Treatment for Dates from _____ to _____

☐ On Site Record Review by Patient ☐ Financial Records ☐ Marketing (Financial compensation is received for this request.)

☐ Psychotherapy Notes—if this box is checked, only psychotherapy notes may be released.

☐ Other as Listed

Reason for Releasing Records (check all that apply):

☐ Moving ☐ Insurance ☐ Providing copy to Primary Care Physician ☐ Dissatisfaction with Practice

☐ I intend to transfer my care to another practice ☐ Other

I would like my records to be (choose one): ◯ Faxed (limit 10 pages) ◯ Mailed ◯ Picked Up

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

PATIENT RIGHTS

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV as well as diagnosis of alcohol/drug abuse or mental health.

Attach the appropriate files (if applicable)

Patient or Personal Representative Signature

Signature of Patient or Personal Representative _____ Date _____

Signature

*Description of Personal Representative's Authority _____