



## Medical Records Release Form (Personal Use)

Fees and Options – Please Select How You Would Like to Receive Records

- Encrypted E-Mail.....FREE
- Family Clinic Portal.....FREE
- CD-ROM.....\$6.50
- Paper Copy..... 1<sup>st</sup> Copy FREE

<b>PATIENT NAME:</b>	<b>DOB:</b>	<b>PHONE:</b>
<b>ADDRESS:</b>	<b>CITY/STATE:</b>	<b>ZIP:</b>
<b>EMAIL:</b>		

**RECORDS REQUESTED FROM (Please select one or both):**

- Hospital
- Family Clinics

**RECORDS TO USE OR DISCLOSE TO:**

- Self
- Other (if other, please fill out below):

<b>NAME:</b>	<b>DOB:</b>	<b>PHONE:</b>
<b>ADDRESS:</b>	<b>CITY/STATE:</b>	<b>ZIP:</b>
<b>EMAIL:</b>		

**Please Release Records for dates:**

- Specific Visit/Account: \_\_\_\_\_ Date Range: \_\_\_\_\_
- Entire Record (includes but not limited to Allergies/Intolerance, Care Team Members, Assessment & Plan, any Clinical Notes, Goals, Health Concerns, Immunization list, Test Results, Medications, Demographics, Problem List, Procedures, Provenance, Smoking Status, Unique Identifier for Patient’s Implantable Devices, and Vital Signs)

**Purpose of Request:** \_\_\_\_\_

**Please select all the specific documents that apply to your request:**

- Clinic Notes
- Radiology Reports
- Nurses Notes
- Emergency Room
- Progress Notes
- Lab Reports
- Operative Reports
- Doctor Consults
- History & Physical
- Pathology Reports
- EKG, EEG, EMG
- Physicians Orders
- Discharge Summary
- Financial/Billing
- Other: \_\_\_\_\_

**Please select the options below to authorize the release of sensitive information pertaining to:**

- Mental Health
- Drugs/Alcohol
- Genetic Testing
- HIV/AIDS/Other Infectious Diseases
- Not Applicable/None of these Apply**



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I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any action taken prior to receiving the revocation.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.
- There is some level of risk that third party could see your PHI without your consent when receiving electronic media or email. Kingman Healthcare Center is not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

I, \_\_\_\_\_, hereby authorize Kingman Healthcare Center (to include the Hospital, Family Clinic, and/or Cunningham Clinic) to disclose confidential health information as indicated on this form.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative Relationship to the Patient

Federal law allows up to 30 days for medical record requests to be processed.

**Please mail this form with payment, if necessary, to:**

Health Information Department  
C/O Kingman Healthcare Center  
750 W. D Ave  
Kingman, KS 67068