

CFC Medical Records Release

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Name _____

Address _____
Street City State ZIP

Home/Cell phone _____ Work phone _____

Date of birth _____

Reason for Request: _____

Please transfer my medical records* as follows:

From: _____ To: Compassionate Family Care LLC

Laura N. Ray, MD/ Morgan Bergman, APRN
Sarah Hohbein PA-C/Jacqueline Steinhoff, APRN
15900 College Blvd, Suite 100
Lenexa, KS 66219
Phone: (913) 744-4300 Fax: (913) 859-9134

***Records to be released:**

- Annual exam and Pap smear / Prostate
- Labs/Xray
- Birth control
- Abortion care
- All medical records
- Other _____

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent. Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

- _____ Drug and/or alcohol abuse, diagnosis or treatment
- _____ HIV/AIDS testing and/or treatment
- _____ Psychiatric care and/or mental illness
- _____ Confirmed STI test results and/or treatment

**THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF SIGNATURE EXCEPT AS SPECIFIED: _____ (SPECIFY DAY OR MONTHS)*

At this time, I understand that this authorization may be revoked in writing by me at any time, except to the extent that this action has been taken. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I also understand that if the requester or receiver of my medical records is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

Signature of Patient or Legal Guardian: _____ Date: _____

Relationship if not the Patient: _____

Signature of Witness: _____ Date: _____