



Kansas City Internal Medicine  
**Authorization of Disclosure of Protected Health Information from another Covered Entity to KCIM**

Patient Name \_\_\_\_\_

D.O.B. \_\_\_\_\_

Patient Address \_\_\_\_\_

Patient Phone # \_\_\_\_\_

Purpose of Request \_\_\_\_\_

Date of Request \_\_\_\_\_

Requesting Records from the Following Physician/Facility:	Please send the following records:
Name  Street Address City/State/Zip  Phone	

Please send the requested records to the KCIM physician named below at the KCIM office location circled:

KCIM Physician: \_\_\_\_\_

**RESEARCH MEDICAL CENTER**  
6420 Prospect Avenue, Suite T-101, Kansas City, MO 64132

**LEE'S SUMMIT MURRAY ROAD**  
506 NW Murray Road, Lee's Summit, MO 64081

**ST. JOE CARONDELET**  
1010 Carondelet Drive, Suite 224A, Kansas City, MO 64114

**LEE'S SUMMIT ST. LUKE'S**  
20 NE St. Luke's Boulevard Suite 350, Lee's Summit, MO 64086

**MENORAH MEDICAL PARK**  
12140 Nall Avenue, Suite 100, Overland Park, KS 66209

I acknowledge and hereby consent to such, that the released information may contain information regarding alcohol abuse, psychiatric, HIV testing and/or results, sexually transmitted disease testing and/or Hepatitis B or C testing and/or results, or other sensitive information. I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary (if I do not sign, then I cannot be given the noted PHI or medical record documents).
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time, in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in KCIM's Notice of Privacy Practices.
4. 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.
5. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy Laws.

I have read the above and authorize the disclosure of the Protected Health Information (PHI) as stated. Please Initial: \_\_\_\_\_

Signature of Patient or Patient Representative (if Patient Representative, must have Power of Attorney or similar legal evidence of such, unless patient is under 18 years of age).

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Patient (or Patient Representative) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KCIM Staff Member Processing this Request

\_\_\_\_\_  
Department/Title