



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

Patient Name _____

D.O.B. _____

Patient Address _____

Patient Phone # _____

Purpose of Request _____

Date of Request _____

KCIM Physician Name _____

Please Send Records to the Following Provider/Facility	Please send the following records:
Name Street Address City/State/Zip Phone	

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