Saint John Hospital

# Release of Information

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

**Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____

**Cell Phone:** _____ **Home Phone:** _____

***I request my protected health information from Saint John Hospital – Leavenworth KS***

1. Who will we be releasing your protected health information (PHI)/medical records to?

**Name:** _____

**Address:** _____ **City:** _____ **State:** ____ **Zip Code:** _____

2. How would you like the medical records delivered:

- ☐ **Email:** _____
- ☐ **Faxed to: (  ) -  -** _____
- ☐ **Pick up in Medical Records**
- ☐ **Mailing Address:** _____ **City:** _____ **State:** ____ **Zip Code:** _____

3. Dates of Service **Specific Date (s):** _____ **to** _____

4. I authorize the following PHI to be released for

| | | |
|---|---|---|
| ☐ Emergency Room Record | ☐ Laboratory Report(s) | ☐ History and Physical |
| ☐ Discharge Summary | ☐ Radiology Report(s) | ☐ Detailed Billing |
| ☐ Hospital Summary (transcribed reports/lab/radiology) | ☐ Cardiology Reports | ☐ Radiology Films |
| | ☐ Pathology Reports | ☐ Pathology Slides |
| ☐ Operative Report | ☐ Sleep Study Records | ☐ Cardiovascular images |
| ☐ Consultants | ☐ Other: please specify_____ | |

5. Purpose for requesting information:

☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

6. By signing this authorization form, I understand that PHI may include records relating to mental health, HIV/AIDS, and/or of alcohol/drug abuse.

**Patient/Authorized Representative Signature;** _____ **Date:** _____/_____/_____ **Time:** _____

**Printed name of Authorized Representative:** _____ **Relationship to Patient:** _____

**Witness Signature:** _____ **Date:** _____/_____/_____ **Time:** _____

☐ **Copy of Photo ID** ☐ **Matching Signature** ☐ **Other** _____

**Medical Records Phone Number: 913-680-6090**
**Fax Number: 913-680-6098**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and Missouri law prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. REV. 04-2018

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