

Authorization to Release Health Information

Patient Name: _____ Date of Birth: _____

RNI Medical Record Number: _____

I authorize the use or disclosure of the above-named individual's protected health information as described below.

The following individual(s) or organizations(s) are **authorized to make the disclosure**:

Dr. Vernon D. Rowe
Rowe Neurology Institute
Consultants in Neurology, PA
8550 Marshall Drive, Suite 100
Lenexa, KS 66214-9836
(913) 827-4200 (P) (913) 827-4201 (F)

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

- | | |
|---|--|
| ☐ medication list | ☐ lab results specify dates: _____ |
| ☐ prescriptions | ☐ MRI or other x-ray reports specify dates: _____ |
| ☐ handwritten progress notes | ☐ insurance cards, insurance face sheet |
| ☐ dictated progress notes | ☐ physicians' orders |
| ☐ diagnostic tests (specify which type and date if possible) | ☐ other (please describe): _____ |
| ☐ date: _____ | |
| ☐ type: _____ | |

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.

The information identified above may be used by or **DISCLOSED TO** the following individual(s) or organization(s):

Facility / Clinician / Individual _____

Address _____

Phone _____ **Fax** _____

This information for which I am authorizing disclosure will be used for the following purpose:

- ☐ my personal records
☐ sharing with other health care providers
☐ other (please describe): _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire (insert date or event): _____. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ Signature of patient / legal guardian	_____ Date signed	_____ (Relationship to Patient) If Signed by legal representative
_____ Signature of witness	_____ Date signed	