Harrisonville Family Medicine

2820 E Rock Haven Road, Ste 100
Harrisonville, MO 64701
Phone (816) 380-3582 / **Fax (816) 380-6964**

Patient Name	Social Security Number	Date of Birth

Releasing records ***FROM:*** _____
(Physician or Organization name)

_____
(mailing address, phone and fax number)

Releasing records ***TO***: _____
(Physician or Organization name)

_____
(mailing address, phone and fax number)

Please select only ONE of the following: I give my permission to release the following records to the above stated entity: (include dates where appropriate)

_____ Confined to records for the time period of:_____

_____ Confined to records regarding the specific information: _____

_____ All records without regard to limitations placed on dates, history of illness, or diagnostic and therapeutic information, including AIDS/HIV testing or diagnosis, information or treatment for alcohol, drug abuse, and testing and diagnosis of psychiatric illness.

For the purpose of: _____

This authorization is voluntary. This authorization will expire in _____ (e.g. 60 days) from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the office in writing, but if I do, it will not have any effect of any actions taken prior to receiving the revocation. I agree to waive all claims against the office for the release of the requested information. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the office if the recipient of the information is not a health plan, health care provider, health clearinghouse, or a business associate that has a contract with the office. I understand that I must provide the office with at least twenty-four (24) hours' notice before coming to the facility to review records. I understand that after I have reviewed the records, I must provide the office with two (2) working days advance notice of any copies of the records that I would like to pick up at the office. I understand that if I wish to have copies of records made, then the office will assess a fee for copying the records. The facility will notify me of the total amount due for copying and shipping of the requested records. I agree that the office will only send me the requested information once payment has been received in full for the charts. I understand that once the requested records leave HFM, they are the responsibility of the patient/recipient. I understand that I have the option to have these records copied to a data disc, or an electronic copy can be made. The patient/recipient will be responsible for providing a flash drive for the electronic copy.

Signature of Patient or Legal Representative _____ Date _____

If Signed by Legal Representative, Relationship to Patient _____ Signature of Witness _____

Revised 6/17/2022