SUMMIT
FAMILY
AND
SPORTS
MEDICINE

SUMMIT FAMILY AND SPORTS MEDICINE
Medical Record Release Authorization

3601 NE Ralph Powell Road, Suite C　　　　　　　　**Phone: 816-285-5053**
Lees Summit, MO 64064　　　　　　　　　　　　　　**Fax: 816-842-1974**

Patient Name_____ Maiden Name_____SS#_____

Date of Birth_____ Home Phone_____ Cell/Work_____
Address_____ City/State/Zip_____
Email Address: _____

A) I hereby authorize records FROM:

Name _____

Address _____

City/State/Zip _____

Phone#_____ Fax# _____

B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone#_____ Fax# _____

C) This request is being made for the following purpose(s): _____

Please release the following medical records and information (specify admission date or period concern)

_____
_____

　　　　I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

　　　　I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

　　　　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 Medical Records Department. I understand that the revocation will not apply to 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.

**　　　I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

_____　　　_____
Signature of Patient/Parent/Guardian or Authorized Representative　　　　　Date

This authorization will expire one year from the above date unless I specify an expiration date: _____
　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　(Expiration date of authorization)

updated 2021