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Wichita, KS 67206  
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### Medical Record Release Authorization

\_\_\_\_\_  
(Patient FULL Name) (Date of Birth) (Social Security Number)

\_\_\_\_\_  
(Address; Street/City/State/Zip) (Home Phone) (Cell/Work Phone)

**I hereby authorize records FROM:**

**To be released TO:**

Name (Facility/Physician) \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Fax#: \_\_\_\_\_ Phone#: \_\_\_\_\_

**For the purpose of:**

- Transfer of Care     Litigation
- Disability         Continuity of Care
- Insurance          Work Comp
- Self/Personal Copy **\*\*Subject to Fees**

**The following information to be disclosed:**

- Treatment dates: \_\_\_\_\_ to \_\_\_\_\_
- Physician Office Notes     Radiology/X-Ray/MRI Reports
- Immunizations             Cardiology/EKG Reports
- Lab/Path Reports          other(specify) \_\_\_\_\_
- Complete Record

**sensitive information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

**redisclosure:** I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules. Copies of records from other health care practitioners contained in Primary Care Associates records may also be made and given upon request. However, we cannot authenticate other providers' copies we have in our possession.

**right to revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

**expiration:** This authorization will expire in one year from the date below unless I specify an expiration date: \_\_\_\_\_

**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 Legal Representative) (Date)

**\*\*PLEASE READ Fee Information:** Primary Care Associates contracts with Chart Request to copy and provide all medical records requested from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you from either Primary Care Associates, LLC or Chart Request upon completion of the data collection. We will not charge a patient for their records when records are sent **Electronically**.