# AUTHORIZATION for RELEASE of MEDICAL RECORDS

**THIS FORM MUST BE FILLED OUT IN FULL BEFORE RECORDS CAN BE RELEASED**

Patient name: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone number: (____) _____-_____

I hereby authorize *Women's Health Associates*, A division of MAPS

(choose one) ☐ release or send my medical records to

☐ obtain my medical records from

Name: _____
(Choose one: ☐ Physician ☐ Patient ☐ Attorney ☐ Insurance Company)

Address: _____
(Street) (City) (State) (Zip Code)

Phone number: (____) _____-_____ Fax number: (____) _____-_____

This authorization is for the release of records pertaining to (check all that apply):

☐ all care

☐ care and treatment for dates from _____to_____

☐ care and treatment specifically related to _____

I hereby give specific permission for the release of records pertaining to (check all that apply):

☐ HIV/AIDS ☐ mental health ☐ alcohol/drug abuse ☐ none of these

Patient Initials: _____ Date: _____

Reason for releasing records (check all that apply):

☐ Moving ☐ Dissatisfaction with Practice

☐ Insurance ☐ Other: _____

☐ Providing copy to Primary Care Physician

I intend to transfer my care to another practice: ☐ Yes ☐ No

I would like my records to be (choose one): ☐ Faxed (limit 10 pages) ☐ Mailed ☐ Picked Up

I understand that I have the 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 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. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed one year):_____. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.**

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 to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure 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 individual or organization making the disclosure.

Patient's Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____

For Office Use Only

Doctor's Signature: _____

Records Release Completed by: _____ Date: _____

☐ Faxed ☐ Mailed ☐ Given to Patient

*** Please know a fee will apply for any medical records that are released directly to the patient. There is no fee to release medical records to another provider. Contact our Medical Records department to obtain a description of copy fees.*


Evelina Swartzman, M.D.
Ana Martinez, M.D.
Reagan Wittek, M.D.
Amy Giedt, M.D.
Kimberly Matthews, M.D.
Kelsi Drummond, M.D.

Phone: (913) 677-3113
Fax: (913) 677-4514

9119 W. 74th St., Suite 300
Merriam, KS 66204

5401 College Blvd.
Suite 100
Leawood. KS 66211