MERITAS HEALTH d/b/a NKC HEALTH MEDICAL GROUP
RELEASE of INFORMATION AUTHORIZATION

Patient Name:____ Date of Birth:______________

Patient Address:______________________________ City: __________ State:______ Zip Code:__________

Phone Number: (   )   - ______________________________

I authorize the release of my protected health information (PHI) from:

☐**NKC Health (Medical Group only)**

- Medical Group / Clinic Name:____
- Address: ____
- If Medical Group / Clinic Name & address are left blank, I understand that all NKC Health Medical Group records within the covered period below will be provided.

I authorize the following PHI to be used and/or disclosed from the above-named patient's medical record.

Specific PHI: ____

____

Covering the period of healthcare **From**:______________________________ **To**:______________________

Except for the following PHI relating to:

☐care and treatment for mental health conditions ☐ sexually transmitted disease(s) testing, status, or care and treatment

☐care and treatment for drug and alcohol abuse ☐ HIV testing, infection status, or care and treatment of HIV/AIDS

☐ genetic testing

I request my protected health information (PHI) be released to:

Name:____ Attention to:______________________

Address: ______________________________ City:__________ State: ______ Zip Code: __________

Phone Number: (   )   - ______________________ Fax Number: (   )   - ______________

Email address: ____

Such disclosure shall be for the purpose of:

☐ Continuation of Care ☐ Legal

☐ Insurance ☐ Self/Personal

☐ Other:

Method of Delivery:

☐CD/DVD ☐Paper

☐Fax ☐Secure Email/Download

By signing this authorization form, I understand that:

- This authorization expires upon the following date or event: __________. If left blank, I agree that this authorization shall be valid for a period of one (1) year from today's date.
- I understand I have the right to revoke this Authorization at any time, except to the extent that NKC Health has already taken action in reliance of this Authorization. I may revoke this Authorization by submitting my revocation in writing to NKC Health, Health Information Management Director, 2800 Clay Edwards Drive, North Kansas City, MO 64116.
- I understand the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be subject to protection under NKC Health's policies and procedures or federal laws protecting the privacy of patients' health information.
- I understand NKC Health does not condition the patient's treatment on my execution of this Authorization and that I may refuse to sign this Authorization.

____

Signature   Date

If someone other than the Patient executes this Authorization:

Printed Name:______________________________

Relationship to Patient:

☐Legal Guardian

☐Parent

☐Other (please specify):