

NORTH KANSAS CITY HOSPITAL d/b/a NKC HEALTH
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 (Hospital only)

- Location / Visit type: _____
- If Location / Visit type is left blank I understand that all Hospital 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 Hospital, 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 _____



Hospital Release of Information
2800 Clay Edwards Dr.
North Kansas City, MO 64116
O: (816) 691-1587 ext. 2
F: (816) 346-7312

If someone other than the Patient executes this Authorization:

Printed Name: _____

Relationship to Patient:

- Legal Guardian
- Parent
- Other (please specify): _____

NKC Health Staff Use Only

MRN:

Initials: