Ottawa Family Physicians
Authorization for Release of Medical Records

I authorize the following protected health information to be released from the medical record of:

_____ _____ _____
Last Name (Please Print) First Name (Please Print) DOB

_____
Address (Street, City, State, Zip)

_____ _____
(Phone Number) (Cell phone Number)

Release Records

From: _____ **To: Ottawa Family Physicians**
Address: _____ 1418 S. Main, Ste 5
City/State/Zip: _____ Ottawa, KS 66067
Phone: _____ Phone: 785-242-1620
Fax: _____ Fax: 785-242-5061

OR

Release Records

To: _____ **From: Ottawa Family Physicians**
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Purpose for the Release:

__Transfer of care Other: _____
(If not for transfer, please state another reason)

Information to be Released:

__Entire Record	__Consultation Reports	__Patient Demographic Info
__Physician Progress Notes	__Operative/Procedure Notes	__Emergency Room Records
__Radiology Reports	__Cardiac Studies	__Patient Demographic Info
__Lab/Pathology Reports	__History & Physical	__Discharge Summary

__OTHER: _____

Date Range of records to be released:

__ All dates of care
__ Date range:_____

I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in processing it. Once this information is released it may no longer be protected by the federal privacy regulations and may be re-disclosed.

I understand that the specified information released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that this authorization will remain in effect for, and expire in, one year from the date it was signed unless I specify a date here (ALLOW AT LEAST TWO WEEKS):_____

I understand there will be a charge based on the Kansas Department of Labor guidelines of $18.97 per request plus $ 0.63 per page up to 250 pages. Any additional pages over 250 will be charged at a rate of $ 0.45. Transferring records from doctor to doctor will not incur charges for the first release.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name & Relationship to Patient Witness