CLAY CENTER FAMILY PHYSICIANS

609 Liberty Street/PO Box 520
Clay Center, KS 67432
Phone – 785-632-2181 fax 785-632-2309

REQUEST FOR MEDICAL RECORDS

I, _____, authorize the following doctor, office or medical practice:
Doctor name/office: _____

Address: _____

Phone: _____ fax: _____

To release medical records for the following patients(s):
ALL PATIENTS OVER 18 MUST SIGN FOR THEMSELVES.

Name: _____ DOB: _____ SS#: _____

Name: _____ DOB: _____ SS#: _____

Name: _____ DOB: _____ SS#: _____

Name: _____ DOB: _____ SS#: _____

_____ All medical records on file.

_____ Designated dates of service listed: _____

The following must be completed prior to signing the authorization.

	INITIALS
I understand and give my consent to the release of information that may contain drug/alcohol information which is protected by federal and state law.	_____
I understand and give my consent to the release of information that may contain mental health information which is protected by federal and state law.	_____
I understand and give my consent to the release of information that may contain information regarding sexually transmitted diseases for HIV/AIDS information which is protected by federal and state law.	_____

Date of expiration: This release is valid for one year (12 months) unless otherwise stated below. This release may be revoked at any time, in writing, but I understand that the cancellation will not affect any information that was already released before the cancelation. I understand that my notice of cancellation MUST be in writing.

_____ _____
AUTORIZED SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE