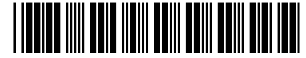
NORTH KANSAS CITY HOSPITAL
AUTHORIZATION FOR RELEASE OF INFORMATION



Patient Name:________________________________
Date of Birth:________________________________
Patient Address:______________________________
Phone Number:________________________________

- I authorize ____________________________________ to use and/or disclose the following health information from the above-named patient's medical record:____________________________ ____.
(describe information, including dates type of conditions, or use checklist on back)

  Except for the following: relating to care and treatment for mental health conditions
  ☐ relating to care and treatment for drug and alcohol abuse
  ☐ relating to HIV testing, infection status, or care and treatment for HIV/AIDS
  ☐ relating to genetic testing

- Such disclosure shall be made to:____ ____
(person or facility, address, city, state and zip code)

- Such disclosure shall be for the purpose of:_____________________________________
(if no purpose is stated, the disclosure is made at my request)
- This authorization expires upon the following date or event: ____________________. If left blank, I agree that this authorization shall be valid for a period of six (6) months from today's date.

- I understand that I have the right to revoke this Authorization at any time, except to the extent that NKCH has already taken action in reliance of this Authorization. I may revoke this Authorization by submitting my revocation in writing to North Kansas City Hospital, Health Information Director, 2800 Clay Edwards Drive, North Kansas City, MO 64116.

- I understand that 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 NKCH's policies and procedures or federal laws protecting the privacy of patients' health information.

- I understand that NKCH 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) ______________________

2800 Clay Edwards Drive
North Kansas City, MO
64116-3220

(816) 691-2000

Refer to Patient Health Information Uses and Disclosures policy

PLACE
PATIENT LABEL
HERE

#8510 4/2022

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IF NOT NOTED ON THE FRONT OF AUTHORIZATION, THE FOLLOWING INFORMATION IS REQUESTED:

_____ Face Sheet
_____ Discharge Summary
_____ History & Physical
_____ Consultation
_____ Operative Record
_____ Pathology Record
_____ Emergency Room Record
_____ Lab Reports
_____ Radiology Reports
_____ EKG
_____ EEG
_____ CT Scan
_____ Nuclear Medicine Reports

_____ Psychiatric Evaluation
_____ Psychological Evaluation
_____ Psychological Test Results
_____ Education Test Results
_____ Problem List / Treatment Plan
_____ Progress Notes
_____ Medication Sheets
_____ Nursing Notes
_____ Consent for Treatment
_____ Social History
_____ (other)_____________________
_____ (other)_____________________
_____ (other)____________________

DOS_____________ Date Copied_______________ By:_______________

LAB	___	PATH	___	D/SUM	___	COMP	___
EKG	___	PROG	___	H&P	___	ABST	___
MED	___	XRAY	___	CONS	___	F/SHT	___
NM	___	OP	___				

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