Cobblestone Family Health *1133 W Kansas St . Liberty, MO 64068 . 816-781-7400 . FAX 816-781-3315*
Dr. John H. Amick, D.O., Dr. John A. Burroughs, M.D., Alicia Muller F.N.P., Sherry Panzica F.N.P.

Request for Access to / Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME: _____
Last First MI

ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____

DAY PHONE: _____EVENING PHONE: _____ CELL PHONE: _____

D.O.B. ___ - ___ - _____
MO DAY YEAR

Cobblestone Family Health is requesting patient records from:
_____
_____

Information will be used/disclosed for the following purpose(s): _____

I hereby authorize disclosure of my protected health information as indicated below to:
NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: _____ **FAX:** _____

◉ **Mail** ○ **Fax** ○ **Hold for pick other than by patient:** _____

Patient or Legal Representative must sign at the bottom of the page prior to records release to the above listed name. This signature authorizes records release to above said name.

INFORMATION TO BE RELEASED:

	Dates:
☐ Discharge Summary	_____
☐ History & Physical	_____
☐ Progress Notes	_____
☐ Lab Reports	_____
☐ X-ray Reports	_____
☐ Medication Records	_____
☐ Detailed Bill/Itemized	_____
☐ Consult Notes	_____
☐ All In-Office Records	

☐ For personal access (specify): ☐ Copy ☐ Inspection ☐ Summary
☐ Other (specify content and dates) _____

I specifically authorize the release of information relating to:
☐ Substance abuse (including alcohol/drug abuse)
☐ Mental health or behavioral health
☐ HIV related information (AIDS related testing)

X_____ _____
SIGNATURE OF PATIENT OR PERSONEL REPRESENTATIVE DATE

ACKNOWLEDGEMENT OF UNDERSTANDING:
Initial each line
_____I understand that this authorization will expire 90 days from dated signed unless otherwise stated _____
_____I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
_____I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
_____By authorizing this use or disclosure of information, there will be no conditions placed on my healthcare unless prior conditions exist.
_____I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.
_____I understand my request will be acted upon with-in 45 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
_____I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, or operations. The fee will not exceed current state limits.

X_____Date: _____Relationship:_____
PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

FOR Cobblestone Family Health Use Only:
Records picked up at CFH Date: _____ ID Verified by: _____ Picked up by: Patient or Above Authorized Individual
Initial Circle One