Pain Management Assoicates • KC Pain Centers

A Division of Anesthesia Associates of Kansas City, P.C.

Patient Name:____ Date of Birth:____________________________

Patient Phone Number:_______________________________ Patient Account Number:___________________________

A)I hereby Authorize records FROM
Name: _______________________________________
Address:_______________________________________
City/State/Zip:___________________________________
Phone #:_________________Fax #:________________

B) To Be Released TO:
Name:____
Address:_______________________________________
City/Sate/Zip:___________________________________
Phone #:_________________Fax #:________________

C) This request is being made for the following purpose(s):____
____

Description of Information to Be Used or Disclosed:

Description	Date(s)	Description	Date(s)	Description	Date
All PHI in medial Record Dictation Reports Physician Orders Clinical Tests Medication Sheets		Special Test/Therapy Nursing Information Billing Record		Itemized Bill Digital Images	

I acknowledge, and hereby consent to such, that released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV Results or AIDS information. _______________(initial).

I understand that:

- I may refuse to sign this authorization and this it is strictly voluntary.
- If I do not sign this form, my health care and payment for health care will not be affected.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy of the information described in this form, for a reasonable fee, if I ask for it.
- I get a copy of this form after I sign it.

This authorization will expire on the following: (fill in the date or the event but not both. If no date or event is specified this authorization will expire one year from date of signature)
Date: ____________________________ Event: ____

____
Name of Patient (Print)

____
Patient (or Patient Representative) Signature Date

____
Staff Member Processing this Request Department/Title

We reserve the right to charge the fee schedule as set by your sate