SIGNATURE
MEDICAL GROUP OF KC, P.A.
PHYSICIANS MAKING A DIFFERENCE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
SIGNATURE MEDICAL GROUP OF KC, P.A.

Patient's Full Name (Print):	
Former Name(s) (where applicable):	
SSN:	**Date of Birth:**
Phone:	**Fax:**

I, or my personal representative, hereby authorize Signature Medical Group of KC, P.A. (Signature or SMG) to use or disclose protected health information (PHI) regarding my care and treatment. I understand that:

1. PHI relating to **ALCOHOL/DRUG ABUSE**, **MENTAL HEALTH**, **GENETIC TESTING**, **HIV/AIDS** and/or communicable diseases may be included in records and I authorize disclosure of such PHI. As applicable, I specifically authorize release of records related to certain treatment or conditions by placing my initials in the appropriate space(s) in Item 8(b).

2. Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV/AIDS information, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who may receive or use my HIV/AIDS information without authorization.

3. I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed in Item 5 below, except to the extent Signature has already relied upon this authorization.

4. Signing this authorization is voluntary. SMG may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

5. Provider releasing this information (one Provider per form): Name: _____

Address: _____ Phone: _____ Fax: _____

6. Purpose for requesting information: ☐ At my request ☐ Continuity of Care ☐ Other: _____

7. Person(s) to receive this information: ☐ Send to Name : _____

Address: _____ Phone: _____ Fax: _____

☐ I will pick it up ☐ My personal representative _____ will pick it up (identification required for pick-up)

Note: Requests are subject to payment of copying/mailing fees and requests may be processed by an SMG business associate

8. Description of information being released: (a) Date(s) of service (required; list all dates)**:** _____

I would like (choose one): ☐ An abstract (pertinent information related to the above listed date(s)) ☐ My entire Medical Record

☐ X-ray/MRI/Other Radiology (specify) _____

☐ Other (specify) _____

(b) Release information relating to (*initial* beside each applicable category): ☐ Alcohol/Drug Treatment _____

☐ Mental Health Treatment _____ ☐ Genetic Testing Information _____

☐ Psychotherapy Notes (complete a separate authorization form for these notes) _____ ☐ HIV/AIDS _____

9. Date or event on which this authorization will end: ☐ One-Time Request ☐ Specific Event or End Date:_____**(Note: Unless otherwise revoked, if no end date/event is specified, this authorization will expire one year from the date signed for Kansas providers)**

10. Signature: By signing below I acknowledge that I have read and agree with all of the above.

Signature: _____ Date: _____/_____/_____

Print name of personal representative if signing for patient and specify authority: _____

(supporting documentation required): ☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Administrator/Executor ☐ Other _____

Note: When an authorization is sought by SMG, a signed copy of this form must be given to Patient or Personal Representative after signing