

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ E- Mail Address: _____

I hereby authorize, _____ [practice name]

at _____ [address] _____ [phone]

to release the medical information described below to Cerner Health Connections, Inc. d/b/a Health^e Clinic.

This Authorization applies to the following information [mark those that apply]:

- Any and all records in the possession of [above practice name], including mental health, HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released.]
- Records regarding the following condition or injury _____ which occurred on or about _____.
- Records covering the period of time _____ to _____.
- Other [please specify – include dates] _____.

My protected health information may be used or disclosed under this Authorization by the above listed persons/entities for the following purposes:

- Personal
- Transfer of care
- Continuation of care
- Other: _____

How information is to be received:

- Fax to (816) 448-0020
- Mail to World Headquarters Clinic
- Mail to Realization Clinic
- Mail to Innovations Clinic

This Authorization expires on: _____.

I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.

- I also understand that certain records/information may be protected by federal or state law, including HIV, psychiatric or mental health treatment, alcohol, drug treatment or communicable diseases, and, unless otherwise specifically indicated, I am requesting that any and all such protected records be released under this Authorization.
- I know I may refuse to sign this Authorization and that my treatment, payment for my treatment or my enrollment or eligibility for benefits will not be affected unless my treatment includes research or the reason for my treatment is to disclose information to another.
- I have read and understand this Authorization. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records/information upon presentation of a photocopy of this Authorization.

Signature of Patient/Personal Representative

Date

Relationship to Patient

World Headquarters

2901 Rockcreek Pkwy
Kansas City, MO 64117

Realization

10234 Marion Park Dr
Kansas City, MO 64137

Innovations

8779 Hillcrest Rd, Bldg. 1024.1
Kansas City, MO 64138

Main: (816) 201-CARE

Fax: (816) 448-0020