WESTGLEN GASTROINTESTINAL CONSULTANTS (WGGI)
DBA: KANSAS CITY NORTH GI

7230 Renner Road
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913-962-2122
913-962-2422 Fax

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913-631-2600
913-631-2606 Fax

DBA Kansas City North GI
6080 N. Oak Traffic Way
Kansas City, MO 64118
816-221-9898
913-962-2422 Fax

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____CITY/STATE/ZIP_____

PHONE: _____

I hereby authorize records FROM:

NAME: _____

STREET ADDRESS: _____

CITY AND STATE: _____ZIP: _____

PHONE #: _____ FAX #: _____

To be released TO:

NAME: _____

STREET ADDRESS: _____

CITY AND STATE: _____ZIP: _____

PHONE #: _____ FAX #: _____

For the purpose of:

_____*Litigation* _____*Disability/SSI*

_____*Insurance* _____*Work Comp*

_____ *Self/Personal Copy* _____*Other*

_____ *Continuity of Care* _____*Transfer of Care (Permanently Leaving)*

_____ *Patient has an appointment on* _____

Date Range _____to _____

- ○ *Physician Office Notes*
- ○ *Immunizations*
- ○ *Operative/Procedure Reports*
- ○ *Other* _____
- ○ *Lab/Path Reports*
- ○ *Radiology/X-rays/US/CT Reports*
- ○ *Entire Chart*

I UNDERSTAND THAT MY MEDICAL RECORDS (INCLUDING ANY PSYCHIATRIC, ALCOHOL, OR DRUG ABUSE INFORMATION) MAY BE PROTECTED BY FEDERAL REGULATIONS. I ALSO UNDERSTAND THAT I MAY REVOKE THIS CONTENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT (E.G. PROBATION, PAROLE, ETC.) AND THAT IN ANY EVENT, THIS CONSENT EXPIRES AUTOMATICALLY AS DESCRIBED BELOW. "I UNDERSTAND THAT MY RECORDS MAY CONTAIN INFORMATION REGARDING THE DIAGNOSIS OR TREATMENT OF HIV, (AIDS VIRUS), OR OTHER SEXUALLY TRANSMITTED DISEASES, DRUG AND/OR ALCOHOL ABUSE, MENTAL ILLNESS OR PSYCHIATRIC TREATMENT. I GIVE MY SPECIFIC AUTHORIZATION FOR THESE RECORDS TO BE RELEASED." CONSENT GOOD FOR ONE (1) YEAR FROM DATE OF PATIENT'S SIGNATURE. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THE AUTHORIZATION IN WRITING EXCEPT TO THE EXTENT OFFICE/HOSPITAL HAS TAKEN ACTION OR HAS RELIED ON THE AUTHORATION. THIS AUTHORATION MAY BE REVOKED BY MY REQUESTING REVOCATION IN WRITING AND DELIVERING A COPY OF THE SAME TO OFFICE/HOSPITAL. THE INFORMATION USED OR DISCLOSED UNDER THE AUTHORATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY LAWS.

_____/_____/_____ _____
DATE (PATIENT'S SIGNATURE)

_____/_____/_____ _____
DATE (PATIENT'S GUARDIAN'S SIGNATURE OR PATIENT'S AUTHORIZED REPRESENTIVE)

_____/_____/_____ _____
DATE (WITNESS)

REV 3/18