Blue Springs Family Care, P.C.
104 NW State Route 7, Suite B
Blue Springs, MO 64014
Phone: (816) 229-8880 Fax: (816) 229-4363
www.bluespringsfamilycare.org

Authorization to Release Information

Anyone 18 or Older Must Sign Own Release

*****Please verify that all information is listed correctly*****

Patient Name: _____

Date of Birth**:** _____ Social Security #: XXX-XX-_____

Home Phone: **(_____) _____-_____** Cell Phone: (_____) _____-_____

Address: _____

City: _____ State: _____ Zip: _____

A) I authorize records **FROM**:

Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone: _____ Fax _____

B) To be released **TO:**

Blue Springs Family Care, P.C.
104 NW State Route 7, Suite B
Blue Springs, MO 64014
Phone: (816) 229-8880
Fax: (816) 229-4363

C) For the purpose of: _____

D) Date Range: From_____ to _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include information relating to sexually transmitted disease, AIDS, HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization is valid only for the release of medical information dated prior to and including the date patient signed the authorization.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature_____Date_____
(Patient/Parent/Guardian or Authorized Representative)

_____/_____
Printed name of authorized representative / Relationship to patient

_____
Witness