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MEDICAL RECORDS RELEASE

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME (Please Print) _____			
FIRST	MI.	LAST	
ADDRESS _____			
	CITY	STATE	ZIP
D.O.B. _____	SSN _____	CONTACT NUMBER _____	

I, _____, would like my complete medical records:

Check One:	Transferred From:	Transferred To:
	Name of Physician: Address: City, State, Zip: Phone: Fax:	Michael J. Barnthouse, M.D. 1010 Carondelet Drive, Suite 328 Kansas City, MO 64114 Phone (816) 941-0700 Fax (816) 941-4189
	Michael J. Barnthouse, M.D. 1010 Carondelet Drive, Suite 328 Kansas City, MO 64114 Phone (816) 941-0700 Fax (816) 941-4189	Name of Physician: Address: City, State, Zip: Phone: Fax:

I understand this authorization may be revoked in writing at any time except already acted upon. I understand that any release that was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

This authorization expires on _____ or within one (1) year of the date signed, if I have not provided an expiration date or event.

I understand that my information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and would no longer be protected by the Privacy Regulations. A copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient or Authorized Representative	Date	Relationship to Patient if Authorized Representative
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Witness: _____

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is ~ sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.