Medical Record # _____

THE UNIVERSITY OF KANSAS HOSPITAL
AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ born on _____, hereby authorize the University Of Kansas Medical Center, 3901 Rainbow Boulevard, Kansas City, Kansas, 66160-7280, to disclose to: _____

_____

_____

the following information: (be specific) _____

_____

_____

The purpose of this request is: _____

_____

I understand once the above information is disclosed, it may be re-disclosed by the recipient, and may no longer be protected by Federal Privacy Laws.

My treatment can not be conditional upon completing this authorization form unless the treatment is for the sole purpose of creating information for disclosure to a third party.

I understand that I may revoke this authorization in writing by notifying the KUMC Medical Records Department at any time except to the extent that action has been taken in reliance on it.

SPECIFICATION OF DATE, EVENT, OR CONDITION UPON WHICH THIS AUTHORIZATION EXPIRES:

_____
(No more than one year following the signature date.)

EXECUTED THIS _____ DAY OF _____, 20_____.

_____ _____
(Witness) (Signature of Patient or AUTHORIZED REPRESENTATIVE)

_____

(Nature of Relationship)

_____ _____

ID Verification (Drivers License #, Social Security #, Photo ID) (Address of Person Signing Authorization)

_____

City State Telephone