REPRODUCTIVE RESOURCE CENTER
20 years of Innovation

AUTHORIZATION TO RELEASE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, date of birth _____, consent to and authorize:
(please print)

Reproductive Resource Center of Greater Kansas City, P.A. (the "Practice")
12200 W. 106th, Suite 120, Overland Park, KS. 66215 Phone: 913-894-2323 Fax: 913-894-0841

to furnish to:
Physician Name:_____
Practice Name: _____
Address: _____
City, State, Zip _____
(i.e. person or facility, address, city, state, zip)

the following medical records and information: _____
(i.e. all, dates of service, admission date, or period concerned)

for the following purposes: _____ (list all purposes).
(i.e. medical, financial, medical and financial)

I specifically authorize the release of types of information **initialed** below:

_____ Alcohol and drug abuse treatment
_____ HIV status or AIDS
_____ Third Party Reproduction (donor egg, donor sperm, gestational carrier)
_____ Mental health
_____ Genetic information

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a request in writing to: Toni Clark at Reproductive Resource Center of Greater Kansas City, P.A. This authorization expires on _____ (date or event) or within one (1) year of the date signed if I have not provided an expiration date or event. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I authorize the release of my entire medical records containing all information provided to or developed by the Practice including information in the record associated with third parties relating to (check one):

☐ Treatment rendered prior to the date this authorization is signed
☐ Treatment rendered both before and after the date this authorization is signed
☐ Treatment rendered only after the date this authorization is signed

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

_____ _____
Date Signature of Patient

Sign if Personal Representative i.e. parent of minor child: _____
If Personal Representative, Relationship to Patient: _____ Date _____

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 NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.