AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ______________________________ Date of Birth: __________ Social Security # _____________

Patient Address: _______________________________________ City/State/Zip ______________________________

Provider's Name: ____

Recipient's Name: **Transplant Institute 2340 E Meyer Blvd, Bldg 2, Ste 646 Kansas City, MO 64132**
Phone # 816-822-8257 Fax # 816-276-4857

This authorization will expire on the following (Fill in the Date or the Event but not both)
Date: _________________________________ Event: __TRANSPLANT_________________________________

Note: The expiration date cannot exceed 1 year from the current date

Purpose of disclosure:__TRANSPLANT EVALUATION____

Description of Information to be used or disclosed

Is this request for psychotherapy notes?

☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

☐ No, then you may check as many items below as you need.

Description	Dates	Description	Dates (s)
☐ Ambulance Report		☐ Nursing Notes	
☐ Cardiac Catheterization		☐ Operative report	
☐ Conditions of Admission		☐ Pathology report	
☐ Consult reports		☐ Physician orders	
☐ Delivery room report		☐ Progress notes	
☐ Discharge summary		☐ Radiology report	
☐ Electro physiology study		☐ T-Echo	
☐ Emergency Room record		☐ Itemized billing statement	
☐ Facesheet		☐ Entire medical record	
☐ History & Physical Exam		☐ Transplant Evaluation Records	
☐ Laboratory reports		☐ Other:	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I may have a copy of this form, once I sign it, if I ask for it.

I have read the above and authorize the disclosure of the protected health information as stated.

_____________________________________ _____________________________________
Signature of Patient or Authorized Representative Date

_____________________________________ _____________________________________
Print Name & Relationship of Authorized Representative Address & Contact Number of Auth Rep