



Mara C. Galvin, MD
 Eugene H. VandenBoom, MD
 Carla R. Pearman, MD
 Cathanie W. Halberstadt, MD
 Lisa L. Amsterdam, MD
 Johanna G. Finkle, MD
 Courtney A. Angell, MD
 Crystal D. Taylor, DO
 Mary E. Brulja, DO
 Susan Ezell, DO

REQUEST FOR THE DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I,

_____ (Print First, Middle Initial and Last Name , Date of Birth and current telephone number)

Consent to and authorize:

_____ (Print Name of person or facility, Address, City, State and Zip and telephone number)

To furnish to Rockhill Women's Care, Inc. the following medical records and information:

_____ (Reason for release of records)

I understand this authorization may be revoked in writing at any time unless it's already acted upon. To revoke this authorization I must send a request in writing to:
 Rockhill Women's Care, Inc., Attention: Medical Records 20 NE Saint Luke's Boulevard, Suite 310 Lee's Summit, MO 64086

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 authorize the release of my records: (check one)

- Only records originated prior to today's date (not including today's date)
- Records originated both before and after today's date (including today's date)
- Records originated only after today's date (including today's date)

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. If Authorized Representative, please also include relationship to patient:

 Signature Date Relationship to Patient

 Witness

20 NE St. Luke's Blvd., Suite 310, Lee's Summit, MO 64086
 (816) 282-7809, (816) 282-7870 Fax

5701 W. 119th St., Suite 225, Overland Park, KS 66209
 (913) 601-4020 , (913) 601-4022 Fax