Rockhill Women's Care

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RELEASE OF INFORMATION REGARDING THE USE OF PROTECTED HEALTH INFORMATION

I,

_____

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

Consent to and authorize Rockhill Women's Care, Inc. to furnish protected health information to:

_____

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

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