GENESIS
PAIN CLINIC
PATIENTFIRST

6700 W 121st Street, Suite 300
Overland Park, KS 66209

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please complete all sections of this HIPPA-compliant release form. If any sections are incorrect or left blank, this form may be invalid and it will not be possible for your health information to be shared, as requested.

Patient Name: _____

Previously Used Names: _____

Date of Birth: _____ SSN#: _____

Patient's Address: _____

Patient's Telephone Number: _____

Information to be disclosed by:	Information to be disclosed to:
Genesis Pain Clinic	
6700 W 121st Street, Suite 300	
Overland Park, KS 66209	
P: 913 871-9888 F: 913 871-1477	

REOUEST:

I, or my authorized representative, hereby authorize Genesis Pain Clinic ("Provider") to use and disclose the following protected health information:

- My complete health record including, but not limited to, dictated clinic notes, diagnostic imaging reports, history and physical reports, operative reports, consultations, labs, and discharge for the following dates: _____ (if left blank, all dates of services leading up to the date this document was executed).

This authorization for release of information is valid through the end of the calendar year, at which time this authorization expires.

I understand that I am permitted to revoke this authorization to share my health data at any time by submitting a written request to the Provider.

In accordance with HIPAA and state and federal regulations, I further understand the following:

l) My records may contain information regarding the diagnosis or treatment related to, but not limited to, mental health/illness records, communicable diseases (including HIV and AIDS), alcohol/drug abuse treatment, or psychiatric treatment.
2) In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
3) I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

4) A fee to disclose the information may be imposed as permitted by state and federal legislation.

Date: _____

Signature of Patient or Legal Representative: _____

Printed Name of Patient or Legal Representative: _____

Relationship to Patient (as applicable): _____

Subscribed and sworn to before the undersigned on the _____ day of _____.

My Appointment Expires: _____.

Notary Public

NAME
Notary Public – Notary Seal
Johnson County – State of Kansas
Commission Number NUMBER
My Commission Expires DATE