Briarcliff Medical Associates, P.C.
5400 North Oak Trwy., Suite 200
Kansas City, MO 64118
Phone: 816-453-0900 Fax: 816-453-6271

Medical Record Release Authorization

Patient Name_____Maiden Name_____SS#_____

Date of Birth_____Home Phone_____Cell/Work_____

Address_____City/State/Zip_____

Email Address: _____

I hereby Authorize:

Name_____

Address_____

City/State/Zip_____

Phone#_____Fax#_____

To send the following information to:

Name_____

Address_____

City/State/Zip_____

Phone#_____Fax#_____

Date Range_____to_____

- ☐ Physicians Office Notes
- ☐ Immunizations
- ☐ Operative/Procedure Reports
- ☐ Cardiology/EKG Reports
- ☐ Lab/Path Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other _____

OR

☐ 2 Years Entire Chart

For the purpose of :_____

_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I gave my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information , I can contact the authorized individual or organization making disclosure.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____***Please Read Fee Information**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)

*Fee Information: Briarcliff Medical Associates contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by the State of Missouri. A $20.65 handling fee, 49 cents per page, and postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.