KANSAS PAIN MANAGEMENT
10995 QUIVIRA ROAD, OVERLAND PARK, KS 66210
Phone: 913.339.9437 Fax: 913.339.9538

PATIENT'S REQUEST FOR RELEASE OF INFORMATION

		PATIENT NAME	
TODAY'S DATE		DATE OF BIRTH	

AUTHORIZATION FOR VERBAL OR WRITTEN RELEASE OF PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONS

AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO KANSAS PAIN MANAGEMENT TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSONS, DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES.

THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.

I AUTHORIZE KANSAS PAIN MANAGEMENT to communicate my health information to the person(s) listed below("Designated Persons") for the following purposes:
-to orally confirm my appointments; to discuss results of my X-ray/MRI/CT or other imaging results,laboratory or other test results; to pick up sample medications or written prescriptions for me; to discuss my health care, diagnosis, prognosis, and treatment plans; and to discuss billing and payment for medical services provided by KANSAS PAIN MANAGEMENT.

I UNDERSTAND that this authorization applies to all departments, healthcare providers and/or employees at
KANSAS PAIN MANAGEMENT.

I UNDERSTAND that this authorization is voluntary.

I UNDERSTAND that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

I UNDERSTAND that this authorization will be effective for my lifetime, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time by sending a written statement of revocation to:

KANSAS PAIN MANAGEMENT
Release of Information Department
10995 Quivira Road
Overland Park, KS 66210

If I revoke the authorization, it will not have any effect on any actions taken by KANSAS PAIN MANAGEMENT prior to the processing of the revocation.

I UNDERSTAND that my refusal to sign this authorization will not negatively affect my health care services at KANSAS PAIN MANAGEMENT.

AUTHORIZATION FOR VERBAL OR WRITTEN RELEASE OF PROTECTED HEALTH INFORMATION TO DESIGNATED PERSON(S) BELOW

NAME		RELATIONSHIP TO PATIENT			
ADDRESS					
CITY		STATE		ZIP CODE	
PHONE		ALTERNATE PHONE			

NAME		RELATIONSHIP TO PATIENT			
ADDRESS					
CITY		STATE		ZIP CODE	
PHONE		ALTERNATE PHONE			

PATIENT PRINTED NAME		PATIENT DOB	

BY SIGNING THIS "Authorization for Verbal Release of Protected Health Information to Designated Persons" AGREEMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS CONTAINED HEREIN. I UNDERSTAND THAT KANSAS PAIN MANAGEMENT WILL PROVIDE ME WITH A COPY OF THIS SIGNED AUTHORIZATION FORM.

PATIENT SIGNATURE		DATE	
PERSONAL REPRESENTATIVE SIGNATURE (If Applicable)		RELATION TO PATIENT	