REQUEST FOR RELEASE OF RECORDS

Patient Name ____ Date of Birth ___________________________

Address ____ City _______________ State/Zip _________________

I, ____, request a copy of my medical record (listed below) from the office of:

____

____

Name and address of practitioner

To be sent to MidAmerica Cancer Care, 2316 E. Meyer Blvd. 1 East, Kansas City, MO 64132
Phone: (712) 322-4136 ext. 61531 | Fax: (816) 683-7368

- New patient MD visit note
- Most recent MD follow up visit note
- Most recent lab results and most recent tumor markers
- All pathology
- All PET/CT scans, CT scans, and radiology
- All genetic results
- Clinical Summary page
- Treatment flowsheet
- 3 months of Chemotherapy calendars

______ I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about or medical records of my medical condition to those persons or agencies named above for continuity of care. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164). A photocopy of this authorization shall have the same effect as the original. If the patient is a minor, this authorization must be signed by a parent or legal guardian. If the patient is physically unable to sign this authorization, he/ she should put an "X" on the signature line and have his/her assent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may only be signed by the next-of-kin or personal representative of the estate.

I understand that the provision of treatment or payment cannot be conditioned on my signing of this authorization unless otherwise permitted under state and federal law. However, if treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this authorization.

I understand that this release is revocable by me at any time, except to the extent that action has already been taken in reliance to it. The request will become effective upon delivery of the written revocation to the disclosing entity. Unless revoked, this authorization for release of information expires in one year after the date of signature.

____ _____________________
Patient Name (Print) Date

____
Patient Date of Birth

____ _____________________
Patient or Guarantor (Signature) Date