bluestem FAMILY HEALTH

Tessa Rohrberg, MD
Amanda Steventon, MD

Patient Name:_____ Birth Date:_____
Maiden Name: _____
Patient Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____Cell Phone:_____Work Phone:_____

I hereby authorize records **FROM**:
Bluestem Family Health
1230 E. 6 Ave Suite 1B
Winfield KS 67156

To be released **TO**:
Facility or Physician:_____
Address: _____
City/State/Zip:_____
Phone:_____Fax:_____

Statement of Understanding

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 to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized 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 understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I am the patient listed or I am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient/Legal Representative:_____Date:_____
Printed Name:_____Relationship:_____

We reserve the right to charge the medical record state fee structure as set forth in the state statute. This fee will be limited to $25 for an electronic copy of the record (PDF format on CD). Paper copies sent directly to the patient will be charged the full rate allowed by Kansas law.

Fax completed form to 248-242-9002

Or mail to:

Cloud 9 Medical Solutions
5371 Plantation Dr
Commerce Twp., MI 48382

Please allow 2-3 weeks for delivery of records
