bluestem FAMILY HEALTH

1230 E 6th Avenue, Suite 1B Winfield KS 67156
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Tessa Rohrberg, MD
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Patient Name:_____ Birth Date:_____
Maiden Name: _____ Social Security #:_____
Patient Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

I hereby authorize records **FROM**: To be released **TO**:
Facility or Physician:_____
Address:_____
City/State/Zip:_____
Phone:_____ Fax:_____

Purpose of the request:

_____Transfer or Continuity of Care _____Self/Personal Copy _____Insurance _____Litigation
_____Disability _____Work Comp _____Other:_____

Records requested:

What specific records may be disclosed: Date Range:_____ to _____

_____Physician Office Notes _____Lab/Pathology Reports _____Immunizations
_____Radiology/X-Ray/MRI Reports _____Cardiology/EKG Reports _____Entire Record
_____Operative/Procedure Reports _____ER Reports

Expiration:

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

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.
