MID AMERICA
HEART & LUNG SURGEONS
"Celebrating 25 years of Heart Transplantation"

CARDIOVASCULAR & THORACIC SURGERY
A. Michael Borkon, M.D.
R. Scott Stuart, M.D.
Alexander Pak, M.D.
Keith B. Allen, M.D.
James R. Stewart, M.D.
J. Russell Davis, M.D.
Sanjeev Aggarwal, M.D.

Authorization for Use and Disclosure of Health Information - Release of Records

- I hereby authorize the use or disclosure of my individually identifiable health information as described below.
- I understand this authorization is voluntary.
- I understand that my health care, payment for my health care, or enrollment or eligibility for benefits will not be affected if I do not sign this form.
- I understand that the information released here may no longer be protected by federal privacy regulations and may be subject to redisclosure.

_____
Patient Name Date of Birth Social Security Number

I hereby request that a copy of my medical records be released to:

MidAmerica Heart & Lung Surgeons
2790 Clay Edwards Drive, Suite 510
North Kansas City MO 64116
Phone 816-842-3353
Fax 816-421-6663

Mid America Heart and Lung Surgeons
4320 Wornall Rd Suite 50
Kansas City, MO 64116
Phone 816-931-3312
Fax 816-531-9862

From: (Person/Organization providing the information)

_____
Name of Person/Organization

_____
Street Address/P.O. Box

_____
City, State and Zip Code

Check all that apply:

____ Discharge Summary ____ Inpatient Records ____ Outpatient Studies

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____ Demographic/Facesheet Information ____ Emergency Room Records

____ History & Physical ____ Office Progress Notes ____ Consultation Notes

____ EKG Report _____ CT/PET Scan Report _____ Chest x-ray Report

____ Lab Results _____ Operative Report _____ Catheterization Report

Other: _____

Dates of Treatment to be Released: _____

Purpose for Disclosure: _____

By state law, you must be advised that the information authorized for release might include records which may indicate the presence of alcohol/substance abuse, mental illness and communicable or venereal disease which may include but is not limited to such diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

I understand that I have the right to revoke this authorization at any time by notifying MidAmerica Heart & Lung Surgeons (Privacy Officer-Colleen Smith) in writing at 4320 Wornall Road, Building II Suite 50, Kansas City MO 64111.

I understand that the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise stated, this statement will expire in 90 days. I understand that the authorization will expire on ___/___/___ (DD/MM/YY).**

_____
Signature of Patient or Legal Guardian Relationship to Patient

_____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

4320 Wornall Road • Medical Plaza II • Suite 50 • Kansas City, Missouri 64111
Phone 816-931-3312 • Fax 816-531-9862

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Phone 816-842-3353 • Fax 816-421-6663