ScanSTAT™ TECHNOLOGIES

Let's make this easier for everyone™

CLAY PLATTE FAMILY MEDICINE CLINIC

Medical Record Release Authorization
Clay Platte Family Medicine

5501 NW 62nd Terrace Suite 100 Kansas City, MO 64151
Phone: 816-842-4440 Fax: 816-842-1974

Patient Name_____ Maiden Name_____SS#_____
Date of Birth_____ Home Phone_____ Cell/Work_____
Address_____ City/State/Zip_____
Email Address: _____

A) I hereby authorize records FROM:

Name _____

Address _____

City/State/Zip _____

Phone#_____ Fax# _____

B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone#_____ Fax# _____

C) For the purpose of:

_____ Litigation _____ Disability/SSI

_____ Insurance _____ Work Comp

_____ Self/Personal Copy _____ Other

_____ Continuity of Care _____ Transfer of Care

Date Range_____to_____

- ☐ Physician Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Immunizations
- ☐ Lab/Path Reports
- ☐ Operative/Procedure Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other _____
- ☐ Minimum Necessary

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 assure treatment. I understand that any disclosure of information carries with it the potential for an authorized redisclosure 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 and present my written revocation to the Medical Records Department. 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 have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____**Subject to fees

Date Signature of Patient/Parent/Guardian or Authorized Representative

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

*PLEASE READ Fee Information: Clay Platte Family Medicine contracts with ScanSTAT Technologies to copy and provide all medical records requested from our office. ScanSTAT Technologies reserves the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you from ScanSTAT Techologies with all the necessary directions to receive your records. By signing this authorization, you are agreeing to pay ScanSTAT Technologies for your records. In the case of continuity of care or personal copy to patient, ScanSTAT Technologies may transfer a minimal portion of your records as a courtesy.

2021 Authorization Form