THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160	**Do not write in this box** DT4068 Request for Records	**TUKHS Office Only** **Medical Record #:** _____ **Date Received:** _____

Radiology Imaging Center

AUTHORIZATION TO RELEASE IMAGES (FILMS) FOR CONTINUED HEALTHCARE

Today's Date _____
Unless otherwise specified in writing by the patient, this authorization will expire within 1 year of the date above.

Patient Last Name: _____First Name: _____Middle Name: _____

Patient's Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

E-Mail Address: (Optional)_____ Phone: _____

Date needed by: _____

Phone of Health Care Provider where images are going: _____

Exams needed: _____
_____

I understand that my Personal Health Information will only be used as described in this authorization. I am also aware that if I choose to share the information defined in this authorization with anyone not directly involved in the use or disclosure described above, HIPAA will no longer protect this information. In addition, I understand that if my personal health information is disclosed to someone who is not required to comply with privacy protections under the HIPAA, then such information might be re-disclosed and will no longer be protected.

PATIENT'S SIGNATURE: _____

Bring or mail the completed form to one of the following locations:

The University of Kansas Health System
Department of Radiology-RIC
4000 Cambridge St., Suite BH 2360
Kansas City, KS 66160
Phone: 913-588-6559
7am – 10pm M-F

Richard and Anette Bloch Cancer Care Pavilion / Westwood Pavilion
2650 Shawnee Mission Pkwy.
Westwood, Ks. 66206
Phone: 913-588-6123
8am – 4:30pm M-F

The University of Kansas Health System
10710 Nall Ave
Overland Park, Ks. 66211
Phone: 913-574-1345
7am – 4:30pm M-F

Department Use Only:
Driver's License or Photo ID *(required when records are picked up)*
Driver's License State: _____ Number: _____
Witness Signature_____Date_____Time_____