McFarland Clinic PC

Request for Release of Medical Information

To ensure that this request is processed in a timely manner, make sure all information is complete. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's signature and date signed or if it has expired. A copy of this signed form will be provided to the patient.

Patient's Full Name ______________________ (PLEASE PRINT) Birth date ______________

Previous Name ______________________ Clinic History # ______________

Daytime telephone number ______________________

Indicate other McFarland Offices where patient has received medical care ______________________

This will authorize:

McFarland Clinic

To release to:

ExamOne
800 NW Chipman Rd. / Suite 5900
POBox 2340
Lee's Summit, MO 64063-1149

Medical information to be released:

I GENERAL RELEASE:

DATES OF TREATMENT

- ❑ Office Notes (This will be limited to 2 years of information including lab and x-ray, unless otherwise specified) From ________ To ________
- ❑ Lab (specify) ________ From ________ To ________
- ❑ X-ray reports (specify) ________ From ________ To ________
- ❑ X-ray films (specify) ________ From ________ To ________
- ❑ Physical Therapy reports From ________ To ________
- ❑ OB Flow Sheet From ________ To ________
- ❑ Immunization From ________ To ________
- ❑ Other (specify) ________ From ________ To ________

II INFORMATION PROTECTED BY STATE/FEDERAL LAW: (You must specifically authorize)

- ☒ Substance Abuse (Alcohol/drug abuse) From ________ To ________
- ☒ Mental Health/Depression From ________ To ________
- ☒ HIV-Related Information (AIDS related testing) From ________ To ________

PURPOSE FOR RELEASE: (check applicable categories)

- ❑ At my request
- ❑ I have been referred to another doctor
- ❑ I am changing doctor
- ❑ Insurance Change
- ❑ Moving (new address) ________
- ❑ Other ________
- ❑ To update my regular doctor (provider)
- ❑ I want/need a second opinion
- ❑ Dissatisfaction with care

I understand that if the person(s) and or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

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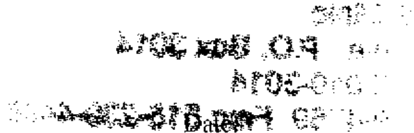
This authorization will automatically expire one year from date of signature or until ______________________, 20______.
I understand that I may revoke this autorization at any time by notifying the providing organizaiton in writing, but if I do, it will not have any effect on any actions they took before they received the revocation.

Any refusal to sign this form will not affect my ability to obtain treatment, payment or my eligibility for benefits. I may request to inspect or copy the health information to be used or disclosed.

Signature of Patient:____ **Date:**______________________
(If signed by person other than patient, state relationship and authority to do so)

Patient is: ❑ Minor ❑ Incompetent ❑ Disabled ❑ Deceased

Legal Authority: ❑ Custodial Parent ❑ Legal Guardian ❑ Executor of Estate of Deceased
❑ Power of Attorney for Healthcare ❑ Authorized Legal Representative
❑ Emancipated Minor



Witness:____ Date:______________________

There is a Service Fee for Medical Record Transfer Requests

A photo ID will be requested for all hand-carry release of information requests.

For Clinic Use Only

Reviewed and approved by

Dr. ______________________________

☐ Patient Pick up Date Needed ______________________

Scan # ______________________
Req. type ______________________
Date completed: ______________________
Processed by: ______________________
Copied by: ______________________