

THE UNIVERSITY OF KANSAS PHYSICIANS

Program in Integrative Medicine Request for Copy of Protected Health Information

I, _____ (print name) born on _____,

OR

I, _____ (print name), the parent and/or Personal Representative of
_____ (print patient name), born on _____,

Hereby request that: _____

Provide a copy of the following information:

Discharge Summary Lab Tests Pathology Reports Psychotherapy Notes

Operative Reports Consultation Reports Radiology Reports Billing Records

Clinic Notes from _____ Clinic Entire Medical Record

Specific Dates only from: _____ to: _____

Other (please specify i.e. monitoring strips, photos, x-rays, etc.) _____

TO: The University of Kansas Physicians
Program in Integrative Medicine
3901 Rainbow Blvd. Mailstop 1017
Kansas City, Kansas 66160

Phone number: 913-588-6208
Fax number: 913-588-0012

The intent of the request described above is for treatment purposes by health care providers and physicians affiliated with UKP.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and may no longer be protected by Federal Privacy Laws.

UKP complies with the HIPAA Privacy Rule for all applicable Protected Health Information (PHI) that is received from another party or covered entity, as described in the KUMC OHCA Notice of Privacy Practices (NPP). A copy of this NPP is available upon request.

SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS AUTHORIZATION EXPIRES:

(No more than one year following the signature date)

EXECUTED THIS _____ DAY OF _____, 20_____

(Print Name of Patient or Authorized Representative)

(Signature of Patient or Authorized Representative)

(Print Witness Name)

ID Verification (Photo ID, Drivers License #)

(Witness Signature)

(Address of Person Signing Authorization)

City

State

Phone #