CENTRAL OFFICE:
800 SW Lincoln St
Topeka, KS 66606
ph. 785.233.5101
fax 785.233.1404

Lincoln Center
OBSTETRICS & GYNECOLOGY, P.A.

URISH OFFICE:
2830 SW Urish Rd
Topeka, KS 66614
ph. 785.273.4010
fax 785.273.8530

FOR OFFICE USE ONLY
☐ *Paper*
☐ *Electronic*
electronic format requested

REQUEST BY PATIENT FOR ACCESS TO PROTECTED HEALTH INFORMATION

Name of Patient **(PLEASE PRINT)** _____ Social Security # _____ Date of Birth _____

Street Address _____ City, State, Zip _____

Maiden or other names used for records _____ DATE THIS AUTHORIZATION EXPIRES *(If no expiration date indicated Authorization will expire 1-year from the date of signature)*

The following protected health information is to be disclosed: (*please check all that apply*)

☐ Complete health record
☐ Pregnancy Records
☐ Surgical Notes
☐ Other _____

Covering the period from _____ to _____

Unless specifically indicated, only up to the last three years of records will be copied

Protected health information in a designated record set includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements and invoices (this includes all records including records from other health care providers).

I understand that if a person or entity receives the described records/information who is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.

I understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.

I understand that I may revoke this authorization at any time by delivering/mailing a written revocation to Lincoln Center OB/GYN, PA, and that if I revoke this authorization it will have no effect on actions already taken on reliance on this form.

I understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I understand that I may have a copy of this form after I sign it.

I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

Lincoln Center OB/GYN, PA out-sources record copying services to Quality Copy Service "QCS". Reasonable fees for the cost of copying, mailing or other supplies associated with your request will be calculated by QCS when records are copied. Their fee must be collected prior to surrendering records. These fees are set annually by the State of Kansas Secretary of Labor.

I hereby agree to pay Lincoln Center OB/GYN, PA for the cost of copying such records. **Please make checks payable to Quality Copy Service.**

Patient's Signature: _____ Date: _____

Signature of Personal Representative of Patient: _____ Date: _____

Personal Representative's Relationship/Capacity to Patient: _____

Representative's Address and Phone Number: _____