



# Heartland Women's Health Care, P.C.

## Release of Medical Records Form

Date \_\_\_\_\_ Med Record # \_\_\_\_\_ Exp Date \_\_\_\_\_

Patients Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Prev Last Name \_\_\_\_\_

New Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

New Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### I Hereby Authorize and Request My Medical Records Be Released

TO     FROM

Heartland Women's Health Care, P.C.  
2790 Clay Edwards Drive, Suite 530  
N. Kansas City, MO 64116  
Fax: 816-453-0677

TO     FROM

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Fax: \_\_\_\_\_

Release All Records       Records From \_\_\_\_\_ To \_\_\_\_\_

Pap Smears       Progress Notes       Pathology       Operative Reports

**Purpose of This Release**

Physician Request     Moving     Insurance Co     Legal

Other \_\_\_\_\_

*This facility, its employees, officers and the physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized. The PHI requested above will not be used for any other reason than to provide direct patient care. The patient may revoke this authorization at any time in writing. Revocation will not apply to information already disclosed in response to this authorization.*

**Charges may apply for copies of records. Please allow up to 10 business days for copying.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Records Copied By

Records were:  Picked up     Faxed     Mailed on \_\_\_\_\_