# Associated Urologists, P.A. /ASC

1133 College Avenue, Bldg. G Suite 100, Manhattan, KS 66502
Telephone (785) 537-8710 Fax (785)537-0562


## Patient consent & authorization for release of medical records

I _____ hereby authorize:

Medical Records Sent From: Name: _____
Address: _____
City, State, Zip Code: _____

Medical Records Released To: Name: _____
Address: _____
City, State, Zip Code: _____

This following information is to be released: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDs or other sexually transmitted diseases, drug and/or alcohol treatment, mental illness or psychiatric treatment. With my initials, I give my specific authorization for these records to be released.
_____HIV/AIDS _____Drug & Alcohol Treatment _____Psychiatric Treatment

Patient's Name: _____
Date of Birth: _____
Patient's Address: _____

I understand that this authorization is voluntary and that Associated Urologists, P.A. /ASC will not condition my treatment or payment on my signing authorization.

I understand I may revoke this authorization at any time by sending a written request to: Associated Urologists, P.A. /ASC, at 1133 College Ave. Bldg. G Suite 100, Manhattan, KS 66502. I also understand that it is my responsibility to verify the receipt of my request either by telephone contact or signature receipt.

I understand if I revoke this authorization it will have no effect on actions already taken in reliance on this form.

There is a charge to release patient's medical records. $18.97(cost of supplies and labor), then $0.63 per page for the first 250 pages, additional pages are $0.45 per page. If records are requested to be sent to a doctor's office, there is no fee. K.S.A. 65-4971 (2012 medical records fees)

Signature (Patient or Patient's Representative):_____
Printed name: _____
Date: _____Relationship to Patient_____

A copy of this authorization will serve the same validity as though and original has been presented.