PATRICK A. NOSTI, MD
Georgetown Medical Building
8901 West 74th Street, Suite 280
Shawnee Mission, KS 66204
P 913.262.3000
F 913.262.3002

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	Date of Birth:	MR#:
Address:	Phone #:	SS#:
City:	State:	Zip Code:

The following individual or organization is authorized to make the following disclosure:

Name:	Address:	
City:	State:	Zip:
Phone:	Fax:	

Admission/Discharge Date(s): _____
Forward to Health Information Management (Medical Records) for:

□ Abstract □ Discharge Summary □ Operative Report □ Emergency Department Report
□ Pathology Report □ History & Physical □ Laboratory Report □ Radiology Report
□ Consultation □ Other _____

Reason for requesting information: ___Patient Care_____

This information may be disclosed to and used by the following individual or organization:

Name: Urogynecology of Kansas City, LLC (Patrick Nosti, MD)	Address: 8901 West 74th Street, Suite 350	
City: Shawnee Mission	State: KS	Zip: 66204
Fax: 913.262.3002	Phone: 913.262.3000	

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed one year): _____ If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed**.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.

Patient Signature: _____ Date: _____
Authorized Representative: _____ Date: _____
Printed Name of Authorized Representative: _____ Relationship: _____
Address & Phone # of Authorized Representative: _____

Urogynecology of Kansas City, LLC

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