Adult and Pediatric Dermatology
4601 W. 109th St., Suite 116
Overland Park, Kansas 66211
913-469-1115

Request for an Individual's Health Information

(Please Print Clearly)

Patient:
Last: First: Middle:

Other Names Used: Date of Birth: SS#

Address:

Primary Phone: Work Phone:

- ☐ Most Recent Progress Note
- ☐ Pathology/Lab Reports
- ☐ X-Ray Reports
- ☐ Entire Health Record
- ☐ Mental Health
- ☐ HIV
- ☐ Billing _____
- ☐ Other:_____

Records From:	Records To:
Name:	Name: **Dr. David L. Kaplan, MD**
Address:	Address: **4601 W 109th St, Ste 116** **Overland Park, KS 66211-1313**
Phone:	Phone: **913.469.1115**
Fax:	**913.469.9446**

Notice:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be one year from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, Adult & Pediatric Dermatology may not condition the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Your Rights:

- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.
- I understand that if my records are released from Adult and Pediatric Dermatology I could possibly be charged a fee for records requested more than once or records that are not kept on site.

This authorization is binding:

- The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in Adult and Pediatric Dermatology's Notice of Privacy Practices.

This completed form can be mailed, faxed (913.469.9446) or emailed (appt@apdkc.com) incomplete forms and digital signatures are not accepted

_____ _____
Signature of Patient, Parent or Legally Authorized Representative Relationship to Patient

_____ _____
Print Patient Full Name Date