Medical Records Release Form

By signing this form, I authorize Clarity DPC to **RELEASE** confidential health information about me, by sending a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Patient name: _________________________________ Date of Birth: ________________________

The information to be released is as follows:

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Initial next to each selection to also include:

_______ Mental Health Information

_______ Genetic Testing Information

_______ HIV/AIDS Information

_______ Substance Abuse Diagnosis/Treatment

Send my protected health information **TO** the following physician/person/facility/entity:

Name: ____

Address: ____

City/State/Zip: ____

Phone: ____________________________________ Fax: __________________________________

____ ________________________________

Signature of Patient or Personal Representative Date

____	________________________________
Printed name	Description of Personal Representative

Clarity DPC
Address: 8350 N St. Clair Ave, Suite 220
Kansas City, MO 64151
Fax: 816-264-1102
Phone: 816-203-1431
Email: info@claritydpc.com