



GET MOVING KC!

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations		
Requestor's Name:		
Address:		
City:	State:	Zip:
This authorization will expire on 1/31/05		
Purpose of disclosure: Receive information about Get Moving KC!		
Description of information to be used or disclosed		
Description: WDAF TV and Health Plus and other participants of Get Moving KC! will receive your name, address, and e-mail address for purposes of providing additional information. <input type="checkbox"/> Other	Date:	
<input checked="" type="checkbox"/> Name <input checked="" type="checkbox"/> Address <input checked="" type="checkbox"/> E-mail address	Date:	
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Research Medical Center Notice of Privacy Practices on http://www.researchmedicalcenter.com . 3. This information is used or disclosed pursuant to this authorization and may be subject to re-disclosure by the recipient. 4. I get a copy of this form after I sign it.		
Section B: Signatures		
I have read the above and authorize the disclosure of the protected health information as stated.		
Signature of Requestor:	Date:	
Print Name of Requestor:		
Address of Requestor:		