CLINICAL
ASSOCIATES, P.A.

Patient Responsibility Form for Record Release

Name _____ DOB:_____
(Please Print)

Clinical Associates, P.A. has numerous policies and procedures in place to keep your records safe and confidential. When we provide those records to you, we no longer have such control and you are responsible for keeping them safe and confidential. We want you to understand that responsibility and not get angry with us for providing you records should something bad or unexpected happen because you did not keep them safe. We also want you to ask us questions about anything that is not understood, confusing or concerns you, as we want you to understand the records as intended and not misinterpret them. *Please note the first set of records will be free, if additional copies are needed there will be a charge. Note: Account balance must be paid in full before your records will be released.*

I understand that I take full responsibility for any reports or medical records provided to me at my request. In the event that my evaluation report or other medical records falls into the hands of others, I do not hold Dr. Cappo, my provider or Clinical Associates, P.A. responsible.

Signature _____ Date _____

Witness _____ Date_____

8629 Bluejacket St., Suite 100 • Lenexa, KS 66214-1604 • 913.677.3553 • 913.677.3282 fax • www.clinical-assoc.com