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CONSERVATIVE CARE
OCCUPATIONAL HEALTH

15319 W. 95th Street
Lenexa, KS 66219
Phone: 913-538-0777 Fax: 913-538-0774

Authorization for Use and Disclosure of Protected Health Information

Date: 5-27-2025 **Patient Name:** Donnie Ralcestraw **DOB:** 8-24-65

FROM: I understand that I am giving authorization and consent for (enter name and address of Provider or entity you want to **send** your records):

Name: Conservative Care Occupational Health

Address/City/State/Zip: 15319 W. 95th St, Lenexa, Kansas 66219

Phone: 913 538 0777 **FAX:** 913 538 0774
Email: lenexafrontdesk@ccohusa.com

TO: Release all of my medical records and medication information to (enter name of provider or entity you want to **receive** your records):

Name: 1785-430-5770 Roger Fincher

Address/City/State/Zip:

Phone: 1-785-430-5770 **Fax:**
Email:

Time Limit & Right of Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Official at 16801 W. Street, Lenexa, KS 66219. Unless revoked, this authorization will expire one year from date of signature. I understand that this consent can be revoked at any time if requested in writing.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that my medical or billing record may contain information in reference to drug or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or sensitive information, I agree to its release.

Re-disclosure: I understand that the information used or disclosed pursuant to an authorization may be subjected to redisclosure by the recipient and no longer be protected by HIPAA Privacy Rules _____ (Initials of patient)

I hereby release CCOH/medical provider from all legal responsibility or liability that may arise from this act I have authorized.

Patient's Signature: [signature] **Date:** 5-27-25
Patient Representative (if patient is unable to sign) _____

CCOH Employee as Witness: Jennifer Anabulsi **Date:** 5/27/25

I personally obtained my medical records and directed the provider to send them to my attorney. Despite this, my attorney never reviewed these records with me, never explained the adverse IME opinions they contained, and never informed me that they were being used to confine my case to workers' compensation only. I relied on counsel to explain the legal significance of these records, and that nondisclosure delayed my discovery of other legal rights, supporting equitable tolling.