Health Care for Children

an affiliate of Children's Mercy

Barry Pointe Office Park
9051 NE 81st Terr, Suite 100
(P) 816-792-1170 (F) 816-792-0729

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Printed Patient Name:_____ Date of Birth:_____

Contact Person:_____ Phone Number:_____

I authorize medical records for the above mentioned patient to be released

FROM:

Name:_____

Address:_____

Phone Number:_____ FAX Number:_____

TO:

Name:_____

Address:_____

Phone Number:_____ FAX Number:_____

REASON FOR TRANSFERRING RECORDS:

_____

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_____ I AGREE AND UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD TO BE RELEASED MAY INCLUDE INFORMATION REGARDING THE DIAGNOSIS AND TREATMENT OF HIV OR OTHER SEXUALLY TRANSMITTED DISEASE, DRUG OR ALCOHOL ABUSE, MENTAL ILLNESS, PSYCHIATRIC TREATMENT OR BIRTH CONTROL.

THIS AUTHORIZATION EXPIRES ON THE FOLLOWING DATE:_____ IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE THIS AUTHORIZATIONT IS SIGNED.

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THE AUTHORIZATION. I NEED NOT SIGN THIS FORM TO ENSURE TREATMENT. I UNDERSTAND THAT I MAY INSPECT THE INFORMATION TO BE USED OR DISCLOSED. IF I HAVE QUESTIONS ABOUT THE DISCLOSURE OF MY HEALTH INFORMATION, I CAN CONTACT THE PRIVACY OFFICER.

_____ _____

Signature of Patient or Guardian Date

_____

Relationship to Patient if signed by Guardian