**HEALTHCARE FOR CHILDREN, P.C.**
**9051 N.E. 81ST TERRACE, SUITE 100**
**KANSAS CITY, MO 64158**
**PHONE (816) 792-1170**
**FAX (816) 792-3877**

THE UNDERSIGNED AUTHORIZES AND REQUESTS HEALTHCARE FOR CHILDREN, P.C.

( ) TO RELEASE TO

( ) TO OBTAIN FROM

FACILITY / PHYSICIAN _____

STREET ADDRESS_____

CITY AND STATE_____

PHONE AND FAX _____

THE FOLLOWING INFORMATION PERTAINING TO MY MEDICAL CARE:

( ) PARTIAL MEDICAL RECORDS – SPECIFY DATES _____

( ) COMPLETE MEDICAL RECORDS

I understand that my medical records may contain information regarding the diagnosis and treatment of HIV or other sexually transmitted diseases, drug and / or alcohol abuse, mental illness, psychiatric treatment or birth control. I give my authorization for these records to be released.

PATIENT REQUESTING INFORMATION:

_____ DATE OF BIRTH_____

PATIENT SIGNATURE_____

PATIENT'S LEGAL GUARDIAN OR

REPRESENTATIVE_____

DATE_____

WITNESS_____

DATE_____