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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Printed Patient Name:_____ Date of Birth_____

Contact Person:_____ Phone Number_____

I authorize_____
name address fax number
to furnish **to** Health Care For Children medical records on the above named patient.

I authorize_____
name address fax number
to receive **from** Health Care For Children medical records on the above named patient

REASON FOR TRANSFERRING RECORDS: _____

_____

☐ 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 (1) year from the date this Authorization 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 disclosure of my health information, I can contact the privacy officer.

_____ Date_____
(Signature of Patient or Guardian)

_____
Relationship to patient if signed by guardian