MEDICAL RECORD RELEASE OF INFORMATION

I hereby authorize my child's protected health information to be disclosed as described below. I understand that this authorization is voluntary:

Patient's Name: _____ Date of Birth: _____

I hereby authorize (please choose one of the following and complete the facility information):

□ Release records **TO** Leawood Pediatrics from the facility listed below.

Release to: Leawood Pediatrics, LLC
5401 College Blvd, Ste 101 • Leawood, KS 66211
(p) 913-825-DOCS (3627) • (f) 913- 948-9128

□ Released **FROM** Leawood Pediatrics to the facility listed below.

□ Self (Please complete the facility/physician information with your personal information)

FACILITY/PHYSICIAN INFORMATION

Facility Name _____ Physician Name: _____

Facility Address: _____

Facility Phone Number: _____ Facility Fax Number: _____

INFORMATION TO BE RELEASED (please choose one of the following):

□ Basic medical records (last well visit, growth charts and immunization records)

□ Complete medical records (put on disc – $25.00 charge applies per child)

□ Charge CCOF □ Bill to my account □Will pay now

Reason for Release □ Specialist □ Transferring to Leawood Pediatrics □ Transferring to a new physician □ Other

Informed Consent for Release of Confidential Information:

I understand that this consent will expire upon delivery of the requested records or 90 days from the date signed (whichever occurs first). Kansas law dictates the rate and fee you may be assessed for your medical records. I understand that under HIPPA guidelines my provider is allowed 30 days to respond to my request for medical records. I understand that the information released is for the specific purpose stated above, that my child's medical records may contain reports only a physician can interpret and only records that have been generated and created by Leawood Pediatrics will be released. I understand and have been advised that I should contact my physician regarding the entries made in my child's medical record to prevent my misunderstanding of the information contained in these entries. I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical records contact person at this site of care except to the extent the action has already been taken to release this information. I have a right to inspect a copy of the health information to be released, and if I do not sign this authorization, facility named above will not release my child's health information. The above named person/facility will not refuse to treat my child based on whether I agree to allow my child's health information to be used and disclosed to others. Notice is hereby given to the recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental treatment.

_____ _____

Parent/Guardian Signature (or Patient if 18 yrs or older) | Date

_____ _____

Printed Parent/Guardian Name & Relationship (or Patient if 18 yrs or older) | Phone Number