GENERAL AUTHORIZATION CONSENT FORM

I, _______________________________________, with the date of birth _________________, hereby authorize
(Patient Name) (Patient DOB)

Leawood Pediatrics, LLC to disclose my health information to the authorized person(s) as described below. I understand that this authorization is volunatary and I may refuse to sign this authorization.

Authorized Person(s) (use additional form for more than 3 people)

____
First and Last Name Relationship to Patient Phone Number

____
First and Last Name Relationship to Patient Phone Number

____
First and Last Name Relationship to Patient Phone Number

I authorize the person(s) listed above to make the following medical decisions (check all that apply):

☐ Well Visit appointment ☐ Sick Visit appointment ☐ Immunization Consent
☐ Procedures ☐ Medication Consent ☐ Other ____________________

I authorize the following information to be released to the person(s) listed above (check all that apply):

☐ Summary Abstract Only ☐ Billing Record ☐ Complete Chart
☐ Consultations ☐ History/Physical ☐ Immunizations
☐ Laboratory ☐ Medication ☐ Nurses' Notes
☐ Progress Notes ☐ Provider Orders ☐ Other: ________________

For the following time period (choose one):

☐ As of this date ______/_______/______ with no end date.

☐ Specific Time Period as indicated ______/_______/______ through ______/______/______ at which time this authorization will be automatically be null and void.

Consent

I understand that personal health information may be released to said authorized person(s) during any visit to Leawood Pediatrics, LLC. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Leawood Pediatrics, LLC. I understand that the revocation will not apply to any medical care given through the receive date of revocation.

____
Patient Name Patient Signature Date Phone