Your Partners in Pediatric & Adolescent Care!
PEDIATRIC PARTNERS, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO PEDIATRIC PARTNERS

Transfer records from:

Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Please Release Information To:

Pediatric Partners, P.A.
7301 W. 133rd Street, Suite 102
Overland Park, Kansas 66213
Phone: 913-888-4567 Fax: 913-888-1277

Information Requested:

☐ Immunization Record/Growth Chart/Last Well Visit
☐ Labs/X-Rays

Informed Consent for Release of Confidential Information.

I understand that I may revoke this consent in writing at any time except to the extent action has already been taken.
I understand that this consent will expire 90 days after the date of my signature unless otherwise specified.
I understand that this information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment, and test results.
I understand that the information released is for the specific purpose stated above.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient