



*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. 133<sup>rd</sup> 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