



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

7301 W. 133rd Street, Suite 102 Overland Park, KS 66213
2111 E. Kansas City Rd Olathe, KS 66061
www.pediatricpartnerskc.com
913-888-4567 | Fax: 913-888-1277