Johnson County Pediatrics

An Affiliate of Children's Mercy

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Complete to permit the disclosure of information to Parent/Guardians if Patient is 18 years old or older)
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. AUTHORIZATION:

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) to: **JOHNSON COUNTY PEDIATRICS**

Patient Name:	Patient DOB:
To: Person/Entity **Receiving** Information: **JOHNSON COUNTY PEDIATRICS**	Relationship to Patient: (if applicable)
Street Address **8800 W. 75th Street, Suite 220**	City, State and Zip Code **Shawnee Mission, KS 66204**
Phone: **913-384-5500**	Fax: **913-384-5209**

2. EFFECTIVE PERIOD:

This authorization for release of information covers the period of healthcare from:

A:	☐	Start Date:	End Date:

****OR****

B:	☐	All past, present, and future periods

3. RECORDS REQUESTED:

☐ Complete record
☐ Last well check, growth chart and immunizations
☐ Other (Please specify): _____

4. EXTENT OF AUTHORIZATION:

A:	☐	I authorize the release of my health record (including but not limited to records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

B:	☐	I authorize the release of my health record with the exception of the following information:

☐ Mental health records;
☐ Communicable diseases (including HIV and AIDS);
☐ Alcohol/drug abuse treatment;
☐ Other (Please specify): _____

5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct;

6. This authorization shall be in force and effect for one (1) year from the date signed or _____, (date or event), at which time this authorization expires;

7. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage at the insurer has a legal right to contest a claim;

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Parent or Guardian Signature (*Patient's signature if 18 or older)*:	Date:

8800 W. 75th, Suite 220, Shawnee Mission, KS 66204 913.384.5500 Fax: 913.384.5209 Email: records@jocopediatrics.com