



Your Partners in Pediatric & Adolescent Care!
PEDIATRIC PARTNERS

An Affiliate of Children's Mercy

**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:

Children's Mercy Pediatric Partners, Inc.
2111 East Kansas City Rd.
Olathe, KS 66061
Phone: 913-888-4567 Fax: 913-888-1277

Information Requested:

- Immunization Record/Growth Chart/Last Well Visit Problem List
 Labs/X-Rays Medication list

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

The parties to this document agree that an electronic signature to make this writing effective and binding and have the same force and effects as the use of a manual signature.