***Premier Pediatrics, P.A.***
*8675 College Boulevard, Suite 100*
*Overland Park, KS 66210*
*913-345-9400 - Office*
*913-345-9408 - Fax*

PREMIER Pediatrics

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

**I hereby authorize the release of information from the medical records of:**

Patient's Name: _____ Date of Birth: ___/___/___

Patient's Name: _____ Date of Birth: ___/___/___

**Please choose one of the following:**

☐ *These records will be released **FROM Premier Pediatrics, P.A. TO the following**:*
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (___) ___ - _____ Fax: (___) ___ - _____
☐ These records will be picked up at Premier Pediatrics by the person listed above.
☐ Please mail records to address above.

☐ *These records are to be released **TO Premier Pediatrics, P.A. FROM the following:***
Practice: _____
Doctor : _____ Phone: (___) ___ - _____
**Please release records to:** Premier Pediatrics, P.A. • 8675 College Boulevard, Ste. 100; O.P., KS 66210 • 913-345-9408 *Fax*

**Information to be released:** ☐ Last well-visit, Growth chart, Immunizations ☐ Other: _____
(please specify the items and/or dates needed)

**Reason for release:** ☐ Leaving Practice ☐ Specialist ☐ Other: _____

## Informed Consent for Release of Confidential Information:

- I understand that this consent will expire upon delivery of the requested records.
- Kansas law dictates the rate and fee you may be assessed for your medical records. (please refer to the "Know your rights…" handout).
- I understand that the information released is for the specific purpose stated above.
- I understand that my medical records may contain reports only a physician can interpret.
- I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
- I will not hold Premier Pediatrics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.
- I understand that only records that have been generated and created from Premier Pediatrics will be released.
- I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent the action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire upon the delivery of the requested records. I have a right t inspect a copy of the health information to be released, and if I do not sign this Authorization, the organization named above will not release my health information. The above named person/organization will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.
- Notice is hereby given to the recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.

(___) ___ -

**Printed Name** of Parent, Legal Guardian, or Patient (if 18 or older) Phone Number

___/___/___

**Signature** of Parent, Legal Guardian, or Patient (if 18 or older) Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
[52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987