PREFERED PEDIATRICS

241 NW McNary Ct.
Lee's Summit, MO 64086
(816) 347-0064
Fax: (816) 347-0593

James McEntire, DO, FAAP
Noel Graham, MD, FAAP
Sherri Quick, R.N., M.S.N., C.P.N.P.
Ebony Kurtz, R.N., M.S.N., C.P.N.P.

MEDICAL RECORD RELEASE AUTHORIZATION

Patient name/date of birth:_____ Home Phone:_____

Patient name/date of birth:_____ Address:_____

City/State/Zip:_____

I hereby authorize records FROM: **To be released TO:**

Name:_____ Name:_____

Address:_____ Address:_____

City/State/Zip:_____ City/Sate/Zip:_____

Phone#_____ Phone#_____

For the purpose of release:

Date Range _____to_____

__Insurance __Other __Physicians office notes __Lab/XRay reports
__Self/Personal __ Transfer __Immunizations __Other

*I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify a expiration date:_____

*(There is a service and copying fee for copies of medical records. We will send a copy of the immunization record, growth chart and problem sheet at no charge. For any subsequent copies there will be a $15.00 base handling fee plus a charge of $0.35 per page of the record. By signing this release of information I fully realize that this action releases said physician from liability for any breach of confidentiality of medical information. This release is effective for 90 days from the date on which it was signed.)