AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Please Choose One Option:

☐ I authorize (Current Doctor's Office) _____

TO FURNISH TO Redwood Pediatrics the medical records on the above-named patient.

9151 NE 81st Terrace #240
Kansas City, MO 64158
(816) 207 – 0070
Fax (816) 256 - 2806

☐ I authorize Redwood Pediatrics **TO RELEASE MY MEDICAL RECORDS TO**

Doctor or Facility _____

Address _____ State _____ Zip _____

Phone _____ Fa x _____

REASON FOR TRANSFERRING RECORDS:

_____

_____ I agree and understand that the information in my health record to be released may include information regarding the diagnosis and treatment of HIV or other sexually transmitted disease, drug or alcohol abuse, mental illness, psychiatric treatment or birth control.

This Authorization expires on the following date:_____ If left blank, this authorization will expire (1) year from the date this authorization is signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I do not need to sign this form to ensure treatment. I understand that I may inspect the information to be used or disclosed. If I have questions about disclosure of my health information, I can contact the privacy officer.

_____ Date_____

(Signature of Patient or Guardian)

_____

Relationship to patient if signed by guardian