

# PEDIATRIC CARE SPECIALISTS, P.A.

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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

Patient Name(s): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### I authorize:

Pediatric Care Specialists  
12541 Foster Suite 260  
Overland Park, KS 66213

### Release Medical Records to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Reason for release of records:

- Change of Insurance  
 Transfer of care  
 Moving out of area  
 Personal (Specify): \_\_\_\_\_

### I would like my medical records:

- Picked up: Date: \_\_\_\_\_  
 Mailed to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Please release the following:

- Last Physical  
 Basic Medical Records (Including: Last Physical with Labs, Immunization Records, Growth Charts, and Problem Sheet.)  
 Full Medical Records (Including: Complete Medical Records.)

**Please Note:** Basic medical records are free of charge. If full medical records are being requested, charts less than 20 pages are free of charge. For charts of 21 or more pages, there will be a \$35.00 charge per copy, per child. Medical records over 10 pages will not be faxed. Please allow two/three weeks for records to be copied. **Initial:** \_\_\_\_\_

### Restrictions:

Only medical records originated through this healthcare facility will be copied unless otherwise requested. Use of this information for any other than the stated purpose is prohibited. This information is for the use of the designated recipient only and cannot be provided to any other agency without consent.

I authorize the release of all information indicated and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical, drug, and/or alcohol abuse. I authorize the release of AIDS/HIV testing. **Initial:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** This consent is valid for 90 days. It may be revoked by the signer at any time.

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