PEDIATRIC CARE SPECIALISTS, P.A.

Harvey M. Grossman, M.D., FAAP
Carolyn T. Davis, M.D., FAAP
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Robert J. Schloegel, M.D., FAAP
Claire D. White, M.D., FAAP
Megan Bolch, PhD, LP
Jason A. Wichman, M.D., FAAP

Mindy Wajcman, R.N., B.S.N.
Hannah B. Harris, A.R.N.P.
Stacey P. Shoman, A.R.N.P.
Sue Hook, Office Manager

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION
TO
PEDIATRIC CARE SPECIALISTS, P.A.

Patient Name(s), Date of Birth:

_____

_____

_____

_____

Address:_____

City:_____**State:**_____**Zip Code:**_____

Phone Numbers: (H)_____**(C)**_____**(W)**_____

I authorize:
(former physician, office or medical facility by name & address):

_____

_____

_____

_____

- **Release all medical records pertaining to above referenced patient(s) to:**
  PEDIATRIC CARE SPECIALISTS
  12541 FOSTER
  SUITE 260
  OVERLAND PARK, KS. 66213

OR

- **I wish to pick up all medical records pertaining to above referenced patients on _____.**

Please contact me at the above referenced phone number if there will be a delay beyond 1 (one) week or past the date indicated for personal pick-up of records.
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 (if any). **INITIAL:_____**

Signature:_____**Date:**_____
Patient, Parent, or Legal Guardian