AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION FROM PEDIATRIC CARE SPECIALISTS, P.A.

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)

Patient Name		Date of Birth	
Address	City	Zip	Phone

RELEASE FROM: [Name of physician or facility releasing information]

I authorize release of my medical record ***from***

Physician/Facility **Pediatric Care Specialists**			
Address **12541 Foster, Suite 260**	City, State **Overland Park, Ks**	Zip **66213**	Phone **913-906-0900**

RELEASE TO: [Name of physician or facility receiving information]

Please send my medical record to:

Physician/Facility			
Address	City	Zip	Phone

RELEASE INFORMATION

Reason: [ ] Change of insurance [ ] Transfer of care [ ] Adult Care Transfer
[ ] Moving out of area [ ] Specialist consultation [ ] Legal

Please release the following (check all that apply)	Yes	No	Initials
LAST PHYSICAL EXAMINATION			
BASIC MEDICAL RECORDS (Last physical + labs, Immunization Record, & Growth Charts)			
FULL MEDICAL RECORDS (Including: Complete Medical Records)			

- Please allow 2 – 3 weeks for processing.
- Incomplete information will delay processing.
- 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.

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 abuse, or drug and alcohol abuse.
Only medical records originated through this healthcare facility will be copied unless otherwise requested. .

	YES	NO	INITIALS
I authorize the release of HIV/HTLV/AIDS test results.			
I understand that I may be charged for copies. Basic medical records are free of charge. There will be an $18 charge per copy, per child for 21 or more pages. 10 or more pages will not be faxed.			

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

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