

PEDIATRIC ASSOCIATES

PLAZA
4400 Broadway, Ste. 206
Kansas City, MO 64111
Phone: 816.561.8100
Fax: 816.561.8154

LEE'S SUMMIT
701 NW Commerce Dr. #102
Lee's Summit, MO 64086
Phone: 816.554.3646
Fax: 816. 554.3607

AUTHORIZATION for RELEASE of INFORMATION

PATIENT'S NAME: _____

PATIENT'S BIRTHDATE: _____

RESPONSIBLE PARTY: _____

PATIENT'S ADDRESS: _____

PATIENT'S PHONE NO.: _____

AUTHORIZATION:

I authorize _____
(name) (address) (fax number)

to furnish **to** Pediatric Associates medical records including immunizations on the above named patient.

I authorize _____
(name) (address) (fax number)

to receive **from** Pediatric Associates medical records on the above named patient.

I authorize _____
(name) (address) (fax number)

to receive **from** Pediatric Associates immunization records on the above named patient.

I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure but in any event on the SIXTIETH DAY after the date of my signature below.

RELEASE: In consideration of the health care provider's compliance with this request, I fully and forever release Pediatric Associates from any and all liability, claims, damages, suits, and causes of action arising out of, related to, or in any way connected with the release of medical information this document requests and authorizes.

A photocopy or facsimile of this form is as valid as the original.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP to PATIENT: _____