pediatric pa associates
An Affiliate Of Children's Mercy

Transfer of Records

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's name _____ Date of Birth _____

Responsible party _____

Patient's address _____

(City) (State) (Zip code)

Patient's phone number: _____

AUTHORIZATION

RELEASE MEDICAL RECORDS FROM:		RELEASE MEDICAL RECORDS TO:	
Doctor/Hospital	_____	Doctor/Hospital	_____
Street Address	_____	Street Address	_____
City/State/Zip	_____	City/State/Zip	_____
Phone Number	_____	Phone Number	_____
Fax Number	_____	Fax Number	_____

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 expressed revocation, this consent will automatically expire upon satisfaction of the need for disclosure or on the SIXTIETH DAY after the date of my signature below, whichever may occur first.

In consideration of the healthcare provider's compliance with this request, I fully and forever release Pediatric Associates - An affiliate of Children's Mercy, Inc. 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 valid as the original.

Sign name: _____ Date: _____

Print name: _____

Relationship: _____