Authorization for Release of Patient Health Information and Records

Cottonwood Pediatrics
700 Medical Center Dr, Ste 150
Newton KS 67114
Phone: 316-283-7100
Fax: 316-283-7118

Patient's Name ____ ____________________
LAST FIRST MIDDLE INITIAL PATIENT'S DATE OF BIRTH

Patient's Social Security # ________________________ Phone # of patient over 18 ____________________
This number is ☐ My cell ☐ My parent's phone number

Parent's Name ____ ____________________
LAST FIRST MIDDLE INITIAL DAYTIME PHONE NUMBER

I authorize the following organization to release information as stated below from the patient health information record. This authorization is effective for one year beginning: ______________(today's date) and ending ______________(one year from today).

INFORMATION TO BE RELEASED *FROM*:	**INFORMATION TO BE RELEASED *TO*:**
☐ Cottonwood Pediatrics ***OR***	☐ Cottonwood Pediatrics ***OR***
☐ ____________________ Organization/Person Name	☐ ____________________ Organization/Person Name
____________________ Street Address	____________________ Street Address
____________________ City, State, Zip	____________________ City, State, Zip
____________________ Telephone Number	____________________ Telephone Number

TYPE OF RECORDS REQUESTED (Charges for copies of records may be associated with your request)

☐ Health care information related to the following treatment or condition: ____________________

☐ Laboratory/Diagnostic Tests: ____________________

☐ All records, **including growth charts & immunization records**, and any records in these subject areas:
☐ Sexually Transmitted Diseases (includes HIV/Aids) ☐ Drug/Alcohol Abuse Treatment ☐ Mental Illness

☐ Other (specify): ____________________

Purpose or Need for this Information: ☐ Continuing care ☐ Copies for own use
☐ Transfer – age 18 ☐ Transfer – moving ☐ Transfer – other
☐ Other ____________________

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Cottonwood Pediatrics Medical Records Release of Information office at the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date below. A fee may be charged for preparing, copying and sending records.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization.

____________________ ____________________ ____________________
Date Signature of Patient or Legally Responsible Party Relationship to Patient