Cass County Pediatrics & Adolescents
An Affiliate of Children's Mercy
503 N. Scott • Belton, Missouri 64012 • Ph. 816-322-GROW (4769) • Fax 816-322-3508

Medical Record Release Authorization

Patient Name: _____ Date Of Birth: _____

Person Requesting Records: _____ Relationship to Patient: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____ Other Phone: _____

Address: _____ City/State/Zip: _____

I hereby authorize records FROM:

Name: **Children's Mercy-Cass County Pediatrics & Adolescents, Inc.**

Address: **503 N Scott**

City/State/Zip: **Belton, MO 64012**

Phone # **816-322-4769** Fax # **816-322-3508**

To be released TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone# _____ Fax# _____

For the purpose of:

_____

Records Format: Records will always be delivered via user friendly CD or secure patient portal unless noted here:

☐ Please send printed copies via postal Mail
**fee will apply for postal delivery

Date Range _____ to _____

☐ Physicians Office Notes ☐ Immunizations
☐ Lab/Path Reports ☐ Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present me written revocation to the Medical Records Department. 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.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ (Subject to Fees)

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____

(Expiration date of authorization)