# Authorization for the Release of Medical Information

This authorization is effective for 1 year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Pediatric Professional Association (PPA). The information disclosed pursuant to this authorization may be redisclosed by the recipient and will no longer be protected by federal confidentiality laws/regulations. I understand that I have the right to inspect the information to be disclosed upon proper notification to and under conditions established by PPA.

**Instructions:** Make sure all blanks are filled in. Failure to do so may prevent or delay release of info.

**Patient:** Name _____

**Identification:** Date of Birth_____ Phone # _____

Parents Name / Previous Name(s) _____

**Provider:**
Pediatric Professional Association
10600 Quivira Rd., Ste 210
Overland Park, KS 66215

**Information May Be Released To:** Please list any entity/persons information may be released to (nurse, daycare, school, other office):_____

**Name:**_____

**Address:** _____

_____

**Information Requested:**

❑ Designated Records Set (DRS)*: Progress Notes, Immunization records, Growth Chart, and Health maintenance record.

❑ Complete Records** ❑ Billing Records, Date_____

❑ Other_____

* There is no charge for the DRS or immunization records.

** There is a fee for complete records. The fee is $17.50 for materials and labor, .58¢ per page for the first 250 pages, and .41¢ per page thereafter.

**Purpose Of Release:** ❑ Transferring Medical Care ❑ Moving ❑ Insurance Change

❑ At the request of the individual ❑ Other _____

**My Child's Medical Information May Be Disclosed By:** ❑ Fax (____) ____-____ ❑ Mail

❑ Oral Conversation (provided proper verification of the identity of the recipient can be made)

**Signature of Patient if 18 years of age or older** _____ **Date** _____

**Signature of Parent or Legal Representative** _____ **Date** _____

**Relationship to Patient, if not signed by patient** _____

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**

I authorize the release of data and information relating to:

❑ 1. Substance abuse (Alcohol/Drug)
❑ 2. Mental Health Summary (includes psychological testing) $50.00 fee
❑ 3. HIV-related information (AIDS related testing)

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements, prohibit further disclosure without specific written consent of the patient, for as otherwise permitted by such law and or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

**Signature of Patient if 18 years of age or older** _____ **Date** _____

**Signature of Parent or Legal Representative** _____ **Date** _____

**Relationship to Patient, if not signed by patient** _____