

VILLAGE PEDIATRICS
8340 MISSION ROAD, SUITE 100
PRAIRIE VILLAGE, KANSAS 66206
PHONE 913-642-2100
FAX 913-642-2127

CONSENT AND AUTHORIZATION FOR RELEASE OF RECORDS

Please complete the following information:

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the custodian of records of Village Pediatrics to disclose/release the following information (check all that apply).

All Records Immunization Records Other(describe) _____

****Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records listed above to:

Name _____ Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

The information may be used/disclosed for each of the following purposes:

At my request For my health care For payment/insurance transfer to a new physician.

I understand this consent and authorization may be revoked at the time except to the extent already acted upon. This consent and authorization expires on _____ or within one year of the date signed if I have not provided an expiration date. I additionally acknowledge that to the extent secondary medical records have become a part of the medical records and are now being released in response to my consent and authorization, Village Pediatrics can neither attest nor certify the accuracy or completeness of those documents. A photo copy of this consent shall be considered as effective and valid as the original.

Signature

Date

Witness

Date