VILLAGE PEDIATRICS, LLC
8340 MISSION RD, SUITE 100
PRAIRIE VILLAGE, KS 66206
Phone (913) 642-2100
Fax (913) 642-2127

Authorization for Release of Medical Records

To:
Name:_____
Address:_____
City/State/Zip:_____
Telephone:_____
Fax:_____

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION FROM THE MEDICAL RECORD OF:

Patient Name:_____Date of Birth:_____

Patient Name:_____Date of Birth:_____

PLEASE RELEASE INFORMATION TO:
VILLAGE PEDIATRICS,LLC
8340 Mission Rd.,Suite 100
Prairie Village, Kansas 66206
Phone: 913-642-2100 Fax: 913-642-2127

Informed Consent for Release of Confidential Information
I understand that I may revoke this consent in writing at any time except to the extent action has already been taken.
I understand that this consent will expire after 90 days after the date of my signature unless otherwise specified.
I understand that this information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment, and test results.
I understand that the information released is for the specific purpose stated above.

_____ Date_____
Signature of Patient or Legal Representative

_____
Relationship to Patient