Shawnee Mission Pediatrics
An Affiliate of Children's Mercy

7450 Kessler St. Suite 105
Merriam, KS 66204
(913) 362-1660

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Individual requesting records: _____

Relation to patient: _____ Contact Phone Number: _____

Medical Records Request

☐ Immunization History
☐ Last Well Check
☐ Partial Records - Date Ranges:_____
☐ Complete Record **(MAIL OR PICK-UP ONLY)**
☐ Other (specify): _____

PLEASE BE AWARE COMPLETE MEDICAL RECORDS CAN TAKE 2-3 WEEKS TO PROCESS

Reason for Request: _____

I authorize the release of medical records be sent:

TO: (Please specify office name if applicable)	**FROM: Shawnee Mission Pediatrics**
Address: **City, State & Zip:**	**Address: 7450 Kessler St. Suite 105** **City, State & Zip: Merriam, Kansas 66204**
Phone: **Fax:**	**Phone: 913-362-1660** **Fax: 913-362-5916**

I understand the information in the medical record may include information regarding the diagnosis and treatment of HIV and other sexually transmitted diseases, drug and alcohol abuse, mental illness, psychiatric treatment, or birth control. I further understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule. This authorization will expire in 90 days from the date set forth below, unless specifically revoked in writing. I understand that I have the right to revoke this authorization at any time by submitting a written revocation to the practice indicated above. In accordance with these guidelines, my signature below shall provide authorization to release the medical information requested.

Patient's Signature (if applicable):_____ **Date:**_____

Parent/Legal Representative's Signature:_____ **Date:**_____

ELECTRONIC SIGNATURES CANNOT BE ACCEPTED