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:** _____

Medical Records Request:

☐ Immunization History
☐ Last Well Check
☐ Partial Records
Date Ranges: _____

☐ Complete Record
☐ Other:
Please Specify: _____

Reason for Request: _____

I authorize the release of medical records be sent:

TO: Shawnee Mission Pediatrics	**FROM:**
Address: 7450 Kessler St. Suite 105 **City, State & Zip: Merriam, Kansas 66204**	**Address:** **City, State & Zip:**
Phone: 913-362-1660 Fax: 913-362-5916	**Phone: Fax:**

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