Johnson County Pediatrics

An Affiliate of Children's Mercy

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS *Please note: A copy fee may be charged for records*

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Complete to permit the disclosure of information to Parent/Guardians if Patient is 18 years old or older)
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. AUTHORIZATION:

By signing this authorization, I authorize Johnson County Pediatrics, PA to use and/or disclose certain protected health information (PHI) to:

Patient Name:	Patient DOB:
To: Person/Entity **Receiving** Information:	Relationship to Patient: (if applicable)
Street Address	City, State and Zip Code
Phone:	Fax:

2. EFFECTIVE PERIOD:

This authorization for release of information covers the period of healthcare from:

A:	☐	Start Date:	End Date:
****OR****			
B:	☐	All past, present, and future periods	

3. RECORDS REQUESTED:

☐ Complete record ($18 for each child's record)
☐ Last well check, growth chart and immunizations - $5
☐ Other (Please specify): _____ - Cost may vary

4. EXTENT OF AUTHORIZATION:

A:	☐	I authorize the release of my health record (including but not limited to records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
****OR****		
B:	☐	I authorize the release of my health record with the exception of the following information:

☐ Mental health records;
☐ Communicable diseases (including HIV and AIDS);
☐ Alcohol/drug abuse treatment;
☐ Other (Please specify): _____

5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct;
6. This authorization shall be in force and effect for one (1) year from the date signed or _____, (date or event), at which time this authorization expires;
7. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage at the insurer has a legal right to contest a claim;
8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization;
9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Parent or Guardian Signature (*Patient's signature if 18 or older)*:	Date:

For Office Use Only

Date Received: _____/_____/_____ Date paid: _____/_____/_____
Date invoiced: _____/_____/_____ Date records copied & sent _____/_____/_____ Initials: _____

Form 7.0a

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