AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name ____ Date of Birth ___________

Please Choose One Option:

- ☐ I authorize (Current Doctor's Office) ____

  TO FURNISH TO Redwood Pediatrics the medical records on the above-named patient.

  6364 N Cosby Ave
  Kansas City, MO 64151
  (816) 540-1070
  Fax (816) 256 - 2806

- ☐ I authorize Redwood Pediatrics **TO RELEASE MY MEDICAL RECORDS TO**

  Doctor or Facility ____

  Address ____________________________________ State ______ Zip ________

  Phone _______________________________ Fax __________________________

REASON FOR TRANSFERRING RECORDS: ____
____

______ I agree and understand that the information in my health record to be released may include information regarding the diagnosis and treatment of HIV or other sexually transmitted disease, drug or alcohol abuse, mental illness, psychiatric treatment or birth control.

This Authorization expires on the following date: _______________________________________
If left blank, this authorization will expire (1) year from the date this authorization is signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I do not need to sign this form to ensure treatment. I understand that I may inspect the information to be used or disclosed. If I have questions about disclosure of my health information, I can contact the privacy officer.

Signature of Patient or Guardian: Date:

____ __________________

Relationship to patient if signed by guardian:

____