

**HEALTH CARE FOR CHILDREN, P.C.**  
**9051 N. E. 81st TERRACE SUITE 100**  
**KANSAS CITY, MO. 64158**  
**PHONE (816) 792-1170**  
**FAX (816) 792-3877**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Printed Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number \_\_\_\_\_

I authorize \_\_\_\_\_  
name address fax number  
to furnish **to** Health Care For Children medical records on the above named patient.

I authorize \_\_\_\_\_  
name address fax number  
to receive **from** Health Care For Children medical records on the above named patient

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 need not 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