Authorization for Release of Patient Health Information and Records

Cottonwood Pediatrics
700 Medical Center Dr, Ste 150
Newton KS 67114
Phone: 316-283-7100
Fax: 316-283-7118

Patient Name _____ _____
LAST FIRST MIDDLE INITIAL Medical Record #

Parent's Name _____ _____
LAST FIRST MIDDLE INITIAL DATE OF BIRTh

Daytime Telephone (_____) _____ Social Security # _____

I authorize the following organization to release information as stated below from the patient health information record. This authorization covers the time period beginning: ____/____/____ (date) and ending ____/____/____ (date).

INFORMATION TO BE RELEASED *FROM*:	**INFORMATION TO BE RELEASED *TO*:**
☐ Cottonwood Pediatrics ***OR***	☐ Cottonwood Pediatrics ***OR***
☐ _____ Organization/Person Name	☐ _____ Organization/Person Name
_____ Street Address	_____ Street Address
_____ City, State, Zip	_____ City, State, Zip
(_____) _____ Telephone Number	(_____) _____ Telephone Number

TYPE OF RECORDS REQUESTED (Charges for copies of records may be associated with your request)

- ☐ Health care information related to the following treatment or condition: _____
- ☐ Laboratory/Diagnostic Tests: _____
- ☐ All records, including any records in these subject areas:
  - ☐ Sexually Transmitted Diseases (includes HIV/Aids) ☐ Drug/Alcohol Abuse Treatment ☐ Mental Illness
- ☐ Other (specify): _____

Purpose or Need for this Information: ☐ Continuing care ☐ Copies for own use

☐ Other _____

Specify the date, extent or condition upon which this authorization expires _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Cottonwood Pediatrics Medical Records Release of Information office at the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty (60) days from the date below. A fee may be charged for preparing, copying and sending records.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization.

_____/_____/_____ _____ _____
Date Signature of Patient or Legally Responsible Party Relationship to Patient