Authorization for Release of Patient Health Information and Records

COTTONWOOD PEDIATRICS
WWW.COTTONWOODPEDS.COM
700 MEDICAL CENTER DR, STE 150
NEWTON, KS | 67114
P:316-283-7100 | F:316-283-7111

PATIENT NAME — FIRST | MIDDLE INITIAL | LAST | DATE OF BIRTH

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PARENT NAME — FIRST | MIDDLE INITIAL | LAST | PHONE NUMBER

I AUTHORIZE COTTONWOD PEDIATRICS TO

☐ disclose information to: ☐ request information from: ☐ exchange information with (obtain and/or disclose):

ORGANIZATION OR PERSON NAME & RELATIONSHIP TO PATIENT | PHONE # | FAX #

STREET ADDRESS | CITY, STATE, ZIP

PURPOSE OR NEED FOR THIS INFORMATION (choose one):

NOT TRANSFERING: ☐ SPECIALIST USE ☐ COPIES FOR OWN USE ($20 PER CHILD - DISK)

TRANSFERING: ☐ AGE 18 OR OVER ☐ MOVING ☐ LEAVING PRACTICE

This authorization is effective ☐ for 1 year ☐ until (date or event)

TYPE OF RECORDS

☐ Health care information related to the following treatment or condition:

☐ All records, especially growth charts and immunization records

☐ Other (specify):

I understand that:

- I have the right to revoke this authorization at any time
- 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
- the revocation will not apply to information that has already been released in response to this authorization
- 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 one year from the date signed, below.

A fee may be charged for preparing, copying and sending records.

I also understand that:

- treatment is not conditioned upon the execution of this authorization
- 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