



# Authorization for Release of Patient Health Information and Records of Patients 18 or Older to Parent(s) or Guardian(s)

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

Patient's Name

First Name	Middle Initial	Last Name	Date of Birth
			MM/DD/YYYY

Patient's SSN

XXXX-XX-XXXX	Patient's phone number

## PARENTS INFORMATION

Parent's Name

Parent's Name	Phone number

Parent's Name

Parent's Name	Phone number

## TYPES OF RECORDS (charges for copies of records may be associated with your request)

<input type="checkbox"/> <b>All records</b> – includes ALL items listed below	<input type="checkbox"/> <b>I do not consent to release ANY information to parents</b>
---	--

- Immunization records only**
- All tests OR  Lab only OR  Imaging only
- Sexual counseling and/or treatment (includes HIV/AIDS, other STDs and/or pregnancy)
- Drug/alcohol abuse treatment  Mental Illness
- Visit notes
- Other (specify): \_\_\_\_\_

I authorize Cottonwood Pediatrics to release information as indicated above from the patient health information record.

This authorization is effective for one year beginning: \_\_\_/\_\_\_/\_\_\_ (today's date) and ending \_\_\_/\_\_\_/\_\_\_ (one year from today).

- 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 one year from the date shown above. A fee may be charged for preparing, copying and sending records.
- 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.

Date (MM/DD/YYYY)	Signature of patient
-------------------	----------------------

FOR OFFICE USE ONLY	
At clinic discretion: I acknowledge that I have received copies of my child's medical records as described above.	
Date (MM/DD/YYYY)	Signature of parent