

Medical Record Release Authorization

Lee's Summit Physicians Group
1425 NW Blue Parkway
Lee's Summit, MO 64086
Peds: 816-524-5600 IM: 816-554-1918
FAX: 816-554-9537

Raintree Pediatrics
821 SW Lemans Lane
Lee's Summit, MO 64082
Phone: 816-252-4700
FAX: 816-554-9537

Blue Springs Pediatrics
1600 NW South Outer Road
Blue Springs, MO 64015
Phone: 816-554-6520
FAX: 816-554-9537

Name _____ Maiden Name _____ SS# _____

Date of Birth _____ Home Phone _____ Cell/Work _____

I hereby Authorize:

Name _____

Address _____

City/State/Zip _____

Phone# _____ Fax# _____

To send the following information to:

Name _____

Address _____

City/State/Zip _____

Phone# _____ Fax# _____

Date Range _____ to _____	
<input type="checkbox"/> Physicians Office Notes	<input type="checkbox"/> Cardiology/EKG Reports
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Lab/Path Reports
<input type="checkbox"/> Operative/Procedure Reports	<input type="checkbox"/> Radiology/XRay/MRI Reports
<input type="checkbox"/> Other _____	

OR

<input type="checkbox"/> 2 Years Entire Chart

For the purpose of : _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

(Date)

(Signature of Patient/Parent/Guardian or Authorized Representative) ***Please Read Fee Information**

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

*Fee Information: Lee's Summit Physicians Group contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by the State of Missouri. A \$20.02 handling fee, 47 cents per page, and postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records.