Summit Pediatrics
And
Adolescent Medicine

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AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

Patient Name_____Date of Birth: _____

SS#_____ Home #_____Cell/Work_____

Address_____City/State/Zip_____

Email Address_____

A) I hereby authorize records FROM:

Name: Summit Pediatrics

Address: 3171 NE Carnegie Dr Suite A

City/State/Zip: Lee's Summit, MO 64064

Phone#: 816-525-2800

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____ Fax#_____

For the Purpose of:

___Continuity of care/Transfer of care

___Insurance ___Work Comp ___Self/Personal Copy

Records to be copied:

_____Entire Chart ____Immunizations ____Other (Specify) _____

_____Records for the period from_____to_____

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 understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. 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.

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.

_____ _____**Subject to Fees

(Date) **(Signature of Patient/Parent/Guardian or Authorized Representative)**

By signing this release of information, I fully understand that this action releases said physician from liability for any breach of confidentiality of medical information. This authorization expires on _____ or within one year of the date signed if I have not provided an expiration date.

****Fee Information:** Some medical records require a charge of up to **$24.57** processing fee and **$0.56** each page to copy or transfer full medical records. This fee must be paid prior to the copy/transfer of records.