PEDIATRIC CARE NORTH

8781 N. Platte Purchase Drive • Kansas City, MO 64155 • (816) 587-3200 • Fax (816) 587-7644

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION / ACCESS REQUEST FORM

I authorize ____ to release:
(Facility name & address)

Check all that apply

- ❑ ER Report
- ❑ History & Physical
- ❑ Discharge Summary
- ❑ Consultations
- ❑ Diagnostic Imaging
- ❑ (X-Ray) Reports
- ❑ Lab Results
- ❑ Pathology Results
- ❑ Complete Health Record
- ❑ X-ray films/Other diagnostic images
- ❑ Pathology slides
- ❑ Cardiovascular Images
- ❑ Complete billing record/itimized bill
- ❑ Other: ______________________

To:

From the record(s) of:

____
(Patient name)

____
(Date of birth)

____
(Address)

____

____
(Telephone)

____
(Specify date(s) of care or diagnosis to be released)

For the purpose of : Information will be used/disclosed for the following purpose(s):

Drug and/or Alcohol Abuse and/or Psychiatric and/or HIV/AIDS Records Release

If my medical or billing record contains information about drug and/or alcohol abuse, mental health, sexually transmitted diseases and/or other sensitive information, I agree to its release.

Drugs	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Sexually Transmitted Disease	❑ Yes	❑ No
Alcohol	❑ Yes	❑ No	Mental Health	❑ Yes	❑ No	Genetic/Metabolic Testing	❑ Yes	❑ No

Time Limit / Right to Revoke

This authorization will expire 90 days from the day of my signature or on the following date or event (please specify):

If I want to cancel this authorization before it expires, I may submit a written notice to the Health Information Services Team Leader at Pediatric Care North. It is understood that information released prior to my written cancellation was made at my request and with my consent.

Re-disclosure

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. Pediatric Care North, its affiliates, its employees and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

Signature or Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this Authorization and I can inspect or copy the protected health information to be used or disclosed.

______________________________ ______________________________
Signature of Patient or Patient's Representative Date

______________________________ ______________________________
Printed Name of Patient or Patient's Representative Relationship of Patient Representative (if applicable)

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Identity of Requestor Verified via: ❑ Photo ID ❑ Matching Signature ❑ Other Specify ______________________

Verified by: ______________________