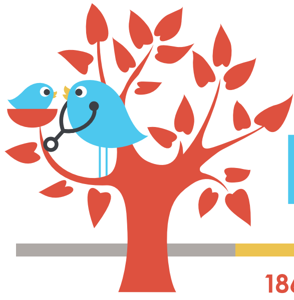

redbudpediatrics LLC

1861 n. rock road, suite 105 | wichita ks 67206 | 316.201.1202 | www.redbudpediatrics.com

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

Patient Name:______________________________ Date of Birth:______________

Patient Address:______________________________ Phone: (   )   -

I hereby authorize the request of medical records from: Physician/Clinic/Hospital:

Address:______________________________

Phone: (   )   -   Fax: (   )   -

Reason for request: ______________________________

To be released to: Physician/Clinic/Hospital:

Address:______________________________

Phone: (   )   -   Fax: (   )   -

Please release the following information:

- ☐ Immunization records
- ☐ Growth charts
- ☐ Lab test results
- ☐ Progress notes
- ☐ Cardiac studies
- ☐ Consultation reports
- ☐ Medical summary (if any)
- ☐ Imaging/radiology reports
- ☐ Other:______________________________

I, the undersigned, have read the above and authorize the disclosure of such protected health information as described herein. I understand that treatment is not conditioned upon execution of this authorization. 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 these regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to Redbud Pediatrics. (Note: Revocation is not effective for disclosures that have already been made.) I also understand that Redbud will send one free copy of medical records to the physician to which I am transferring care and that any other requests for medical records will result in a $25.00 charge.

____

Signature of parent/guardian   Date

____

Printed name of parent/guardian   Relationship to patient