Authorization to Release Patient Medical Information

*Patient Name:*_____*Date of Birth:*_____

Patient Address: _____ *Phone:*(_____)_____

_____

I *hereby authorize:*

Previous Physician/Clinic/Hospital: _____

Address: _____

_____ *Phone: (* _____ *)* _____

to release the following information to **Redbud Pediatrics, LLC:**

X Growth Charts	X Progress Notes	X Hospital discharge summary
X Consultation Reports	X Cardiac Studies	X Imaging/Radiology Reports
X Lab Test Results		X Medical Summary (if any)

X 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 the 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 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.)

_____ _____

signature of parent/guardian *date*

_____ _____

printed name of parent or guardian *relationship to patient*

1861 n rock road, suite 105 | wichita, ks 67206 | phone **316.201.1202 |** fax **316.201.1251 | redbudpediatrics.com**