



 **Children's Mercy**
Authorization for Release of
Medical Information
to Children's Mercy
 8071-195 MR 05/18

| | | | |
|---|------|---------------|-----------------------|
| Patient's Full Name and Previous Names Used | / / | Date of Birth | Medical Record Number |
| Street Address | City | State | Zip Code |

| Information to be Released – Check all that apply. | | | |
|--|--|--|--|
| <input type="checkbox"/> Pertinent Health Information* <input type="checkbox"/> Complete Health Record** (includes all visits and information on record) <input type="checkbox"/> Visit History Only <input type="checkbox"/> Immunization Record <input type="checkbox"/> Emergency department (ER or ED) visit on (date): / / <input type="checkbox"/> Outpatient visit on this date: / / <input type="checkbox"/> Test results for this date: / / | <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Cardiology Images (including EEG, EKG) <input type="checkbox"/> HIV Test Results <input type="checkbox"/> Alcohol and Drug Information <input type="checkbox"/> All Information for This Date Range: <input type="checkbox"/> Other: _____ | | |

| Information will be RELEASED BY – Complete all fields. | | | |
|--|------|---------------------------------|----------|
| Organization: _____ | | | |
| Telephone Number: _____ | | Fax Number: () - _____ | |
| Street Address | City | State | Zip Code |
| Release information by: <input type="checkbox"/> Mail delivery <input type="checkbox"/> Fax <input type="checkbox"/> CD/DVD, if available <input type="checkbox"/> Email, if available | | | |

| Purpose of Release – Check all that apply. | |
|--|-----------------|
| <input type="checkbox"/> Doctor appointment on (date): / / <input type="checkbox"/> Other ongoing treatment or care: _____ <input type="checkbox"/> Other: _____ | Location: _____ |

| Send Information to the following – Complete all fields. | | | |
|--|------|-------------------|----------|
| Organization and/or Name: _____ | | | |
| Telephone Number: _____ | | Fax Number: _____ | |
| Street Address | City | State | Zip Code |

I authorize the use or disclosure of information specified in this authorization regarding the patient named above. I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Health Information Management department of The Children's Mercy Hospital or to the other organization named. Unless this authorization is revoked, it will expire once the disclosure is complete.

I do not need to sign a specific authorization to disclose information for treatment, payment, or health care operations. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have questions about disclosure of my information, I can contact the Health Information Management department of The Children's Mercy Hospital at (816) 234-3455.

| | | | |
|--|-------------------------|---|----------|
| Printed Name of Patient, Parent, or Legal Guardian | Relationship to Patient | () - _____ Telephone Number | |
| Signature of Patient, Parent, or Legal Guardian | | / / Date | |
| Street Address (if different from above) | City | State | Zip Code |