Authorization for Release of Medical Information by The Children's Mercy Hospital

8071-196 MR 09/12

Patient's Full Name and Previous Names Used ____ Date of Birth __/__/__ ____ Medical Record Number ____

Street Address ____ City ____ State ____ Zip Code ____

Information to be Released by The Children's Mercy Hospital (CMH) – Check all that apply.

- ☐ Pertinent Health Information*
- ☐ Complete Health Record**
  (includes all visits and information on record)
- ☐ Visit History Only
- ☐ Immunization Record
- ☐ Emergency department (ER or ED) visit on this date: __/__/__
- ☐ Outpatient visit on this date: __/__/__
- ☐ Test results for this date: __/__/__
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Cardiology Images (including EEG, EKG)
- ☐ HIV Test Results
- ☐ Alcohol and Drug Information
- ☐ All Information for This Date Range: ____
- ☐ Other: ____

*Pertinent Health Information includes treatment documentation but does not include nursing documentation; there is no charge to print.
**Complete record requests will be charged a standard printing rate plus an additional cost per page.

Purpose of Release – Check all that apply.

- ☐ Doctor appointment on (date): __/__/__ Location: ____
- ☐ Other ongoing treatment or care: ____
- ☐ Other: ____

CMH will provide the information requested above to the following party – Complete all fields.

Organization: ____ Telephone Number: ( ) –

Attention: ____ Fax Number: ( ) –

Email address: ____

Street Address ____ City ____ State ____ Zip Code ____

Release information by: ☐ Mail delivery ☐ Pick up ☐ CD/DVD, if available ☐ Email, if available

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 ____