Medical Records Release Authorization

Patient Name_____ SSN_____

Date of Birth_____ Phone_____ Email_____

Address_____ City_____ State Zip_____

A) I hereby authorize medical records from:

Name_____

Address_____

City/State/Zip_____

Phone_____ Fax_____

B) To be released to:

Name_____

Address_____

City/State/Zip_____

Phone_____ Fax_____

Email:_____

C) For the purpose of:

Date Range:_____ to_____

____Continuity of Care _____Litigation

____Self/Personal Copy _____Disability

____Insurance _____Other

____Physician office notes ____Specialist Reports

____Immunizations ____Other

____Lab/Radiology Reports _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re- disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not appl y to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.*

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative Date

This authorization will expire one year from the above date unless I specify an expiration date of authorization: _____.

*Cockerell & McIntosh Pediatrics – an Affiliate of Children's Mercy contracts utilizes Verisma to copy and provide all medical records requested from our office. We reserve the right to subsequently charge the fee schedule as set by the State of Missouri, which may be invoiced to you from Verisma, LLC. By signing this authorization, you are agreeing to pay Verismafor your records.