Authorization for Release of Patient Health Information and Records

700 MEDICAL CENTER DR, STE 150, NEWTON, KS 67114 | P:316-283-7100 | F:316-283-7118 | COTTONWOODPEDS.COM

Cottonwood Pediatrics

PARENT FULL NAME

PARENT/LEGAL GUARDIAN'S FULL NAME

CHILD 1 FULL NAME | DOB

CHILD 2 FULL NAME | DOB

CHILD 3 FULL NAME | DOB

CHILD 4 FULL NAME | DOB

I AUTHORIZE COTTONWOOD PEDIATRICS TO

☐ disclose information to ☐ request information from ☐ exchange information with (obtain and/or disclose)

HEALTH/MENTAL HEALTH PROVIDER | TELEPHONE | FAX

ADDRESS | CITY, STATE AND ZIP CODE

PURPOSE OR NEED FOR THIS INFORMATION

TRANSFERING ☐ age 18 & over ☐ moving ☐ leaving practice

NOT TRANSFERING ☐ continuing care ☐ specialist use ☐ copies for own use ($20 per child – disk)

THIS AUTHORIZATION IS EFFECTIVE FOR (CHOOSE ONE) 1 YEAR _____

TYPE OF RECORDS

☐ All visit notes - please include growth charts and immunization records

☐ Health care information related to the following treatment or condition:

☐ Other (specify)

I understand that:

- I have the right to revoke this authorization at any time;
- in order to revoke this authorization, I must do so in writing and present **my written revocation to Cottonwood Pediatrics Medical Records Release of Information office** at the above address;
- the revocation will not apply to information that has already been released in response to this authorization;
- the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire one year from the date signed below.

A fee may be charged for preparing, copying and sending records.

I also understand that:

- treatment is not conditioned upon the execution of this authorization;
- 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 those regulations.

I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization.

Signature | Date

☐ Mother ☐ Father ☐ Guardian