Authorization for Release of Patient Health Information and Records of Patients 18 or Older to Parent(s) or Guardian(s)

Cottonwood Pediatrics
700 Medical Center Dr.
Ste 150 Newton KS 67114
Phone: 316-283-7100
Fax: 316-283-7118

Patient's Name _____ (First Name) _____ (Middle Initial) _____ (Last Name) Date of Birth _____ (MM/DD/YYYY)

Patient's SSN _____ (xxxx-xx-xxxx) Patient's phone number _____

PARENTS INFORMATION

Parent's Name _____ Phone number _____

Parent's Name _____ Phone number _____

TYPES OF RECORDS (charges for copies of records may be associated with your request)

☐ **All records** – includes ALL items listed below ☐ **I do not consent to release ANY information to parents**

☐ **Immunization records only**
☐ All tests OR ☐ Lab only OR ☐ Imaging only
☐ Sexual counseling and/or treatment (includes HIV/AIDS, other STDs and/or pregnancy)
☐ Drug/alcohol abuse treatment ☐ Mental Illness
☐ Visit notes
☐ Other (specify): _____

I authorize Cottonwood Pediatrics to release information as indicated above from the patient health information record.

This authorization is effective for one year beginning: ____/____/____ (today's date) and ending ____/____/____ (one year from today).

- I understand that I have the right to revoke this authorization at any time.
- I understand that 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. 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 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 in one year from the date shown above. A fee may be charged for preparing, copying and sending records.
- 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 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.

_____ Date (MM/DD/YYYY) _____ Signature of patient

FOR OFFICE USE ONLY

At clinic discretion: I acknowledge that I have received copies of my child's medical records as described above.

_____ Date (MM/DD/YYYY) _____ Signature of parent