Medical Record Release Authorization

□ Lee's Summit Physicians Group	□ Raintree Pediatrics	□ Blue Springs Pediatrics
1425 NW Blue Parkway	821 SW Lemans Lane	1600 NW South Outer Road
Lee's Summit, MO 64086	Lee's Summit, MO 64082	Blue Springs, MO 64015
Peds: 816-524-5600 IM: 816-554-1918	Phone: 816-525-4700	Phone: 816-554-6520
FAX: 816-524-1556	FAX: 816-623-3770	FAX: 816-554-9537

Name ______________________ Maiden Name ______________ SS# ______________

Date of Birth ______________ Home Phone ______________ Cell/Work ______________

I hereby Authorize:

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone# ______________ Fax# ______________

To send the following information to:

Name ______________________

Address ______________________

City/State/Zip ______________________

Phone# ______________ Fax# ______________

Date Range ______________ to ______________

- ☐ Physicians Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Immunizations
- ☐ Lab/Path Reports
- ☐ Operative/Procedure Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other ______________________

OR

☐ 2 Years Entire Chart

For the purpose of : ______________________

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I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

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 to 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 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.

***Please Read Fee Information**

______________________ (Date)

______________________ (Signature of Patient/Parent/Guardian or Authorized Representative

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

(Expiration date of authorization)

*Fee Information: Lee's Summit Physicians Group contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by the State of Missouri . A $21.36 handling fee, **50** cents per page, and postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records.