



**Preferred Pediatrics**

824 W. Frontier Lane • Olathe, Kansas 66061 • (913) 764-7060

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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION**

Patient Name(s): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I Authorize: Preferred Pediatrics  
824 W Frontier Lane  
Olathe, KS 66061  
Fax: (913) 764-8059

Release to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Fax: \_\_\_\_\_

Reason for Release of Records:

- Change of Insurance
- Moving out of Area
- Transfer of Care
- Personal

I would like the following records:

- Immunization Record
- Basic Medical Record (shot records, problem sheet, growth chart)
- Entire Chart\*\*
- Other: \_\_\_\_\_

\*\*There is a service and copying fee for copies outside of the basic medical record. The charge is \$18 per chart plus .60 cents per page.

By signing this release of information I fully realize that this action releases said physician from liability for any breach of confidentiality of medical information. This release is effective for 90 days from the date on which it was signed.

\_\_\_\_\_  
Signature of Patient, Parent, or Guardian      Date      Relationship to Patient