



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: _____

Address: _____ City/State: _____ Zip Code: _____

I Authorize: _____

Release to: Preferred Pediatrics
824 W Frontier Ln
Olathe, KS 66061
Fax: 913-764-8059

Reason for Release of Records:

- Change of Insurance
- Transfer of Care
- Moving out of Area
- Personal (Specify): _____

I would like my Medical Records:

- Picked up: Phone _____
- Fax: _____
- Basic Medical (Imm., Problem sheet, Growth Chart)
- Immunizations only
- Entire Chart

*There is a service and copying fee for copies of Medical Records. We will send a copy of the Immunization Record, Growth Chart, and Problem Sheet at no charge. 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

Relationship to Patient

Date

Witness

Do you have legal custody of child(ren) Yes No Please Explain: