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

Stuart G. Shanker, M.D., FAAP
F. Lance Miller, M.D., FAAP
Amy L. Voelker, M.D., FAAP
Allison S. Hettinger, M.D., FAAP

# 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 breech 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