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

I would like my Medical Records:

- ☐ Picked up: Phone _____
- ☐ Immunizations only
- ☐ Fax: _____
- ☐ Entire Chart
- ☐ Basic Medical (Imm., Problem sheet, Growth 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 breech of confidentiality of medical information. This release is effective for 90 days from the date on which it was sighed.

_____ _____
Signature of Patient, Parent, or Guardian Relationship to Patient

_____ _____
Date Witness

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