VILLAGE PEDIATRICS
8340 MISSION RD, SUITE 100
PRAIRIE VILLAGE, KS 66206
913-642-2100
913-642-2127(FAX)

MEDICAL RECORD RELEASE OF INFORMATION

Patient's Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

I authorize the custodian of records of Village Pediatrics to disclose/release the following information (check all that apply).

____ Basic medical records (last well visit, growth charts, and immunization records)

____ Complete medical records (on disc) $20.00 per child

****NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.**

____ Please release records to Village Pediatrics at 8340 Mission Rd, Ste 100, Prairie Village, Kansas, 66206.

____ Please release records from Village Pediatrics to the facility listed below:

Facility Name: _____ **Physician Name:** _____

Facility address: _____

Facility Phone Number: _____ **Fax Number:** _____

I understand that this consent will expire upon delivery of the requested records. I understand that under HIPPA guidelines my provider is allowed 30 days to respond to my request for medical records. Kansas law dictates the rate and fee you may be assessed for your medical records. I understand that the information released is for the specific purpose stated above, that my child's medical records may contain reports only a physician can interpret and only records that have been generated from Village Pediatrics will be released. I understand that if I do not sign this authorization the facility named above will not release my child's health information.

_____ _____

Parent/Guardian Signature
(Patient if 18 years or older)

Date