



# Authorization for Release of Medical Information by The Children's Mercy Hospital

8071-196 MR 09/12



Patient's Full Name and Previous Names Used		Date of Birth	Medical Record Number
Street Address	City	State	Zip Code

**Information to be Released by The Children's Mercy Hospital (CMH) – Check all that apply.**

<input type="checkbox"/> Pertinent Health Information*	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Complete Health Record** (includes all visits and information on record)	<input type="checkbox"/> Radiology Images
<input type="checkbox"/> Visit History Only	<input type="checkbox"/> Cardiology Images (including EEG, EKG)
<input type="checkbox"/> Immunization Record	<input type="checkbox"/> HIV Test Results
<input type="checkbox"/> Emergency department (ER or ED) visit on this date:     /     /	<input type="checkbox"/> Alcohol and Drug Information
<input type="checkbox"/> Outpatient visit on this date:     /     /	<input type="checkbox"/> All Information for This Date Range:
<input type="checkbox"/> Test results for this date:     /     /	<input type="checkbox"/> Other: _____

\*Pertinent Health Information includes treatment documentation but does not include nursing documentation; there is no charge to print.  
\*\*Complete record requests will be charged a standard printing rate plus an additional cost per page.

**Purpose of Release – Check all that apply.**

Doctor appointment on (date):     /     /     Location: \_\_\_\_\_

Other ongoing treatment or care: \_\_\_\_\_

Other: \_\_\_\_\_

**CMH will provide the information requested above to the following party – Complete all fields.**

Organization: \_\_\_\_\_ Telephone Number: (     )     -     

Attention: \_\_\_\_\_ Fax Number: (     )     -     

Email address: \_\_\_\_\_

Street Address     City     State     Zip Code

Release information by:  Mail delivery    Pick up    CD/DVD, if available    Email, if available

I authorize the use or disclosure of information specified in this authorization regarding the patient named above. I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Health Information Management department of The Children's Mercy Hospital or to the other organization named. Unless this authorization is revoked, it will expire once the disclosure is complete.

I do not need to sign a specific authorization to disclose information for treatment, payment, or health care operations. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have questions about disclosure of my information, I can contact the Health Information Management department of The Children's Mercy Hospital at (816) 234-3455.

Printed Name of Patient, Parent, or Legal Guardian	Relationship to Patient	(     )     - Telephone Number
Signature of Patient, Parent, or Legal Guardian		/     / Date
Street Address (if different from above)	City	State     Zip Code