SHAWNEE MISSION PEDIATRICS, P.A.

REQUEST FOR RELEASE OF MEDICAL RECORDS (FROM OUTSIDE PROVIDER)

Patient Name:_____ **Date of Birth :**_____

Individual requesting records:_____ **Relation to patient :**_____

I hereby authorize and request the release of:

- ☐ Immunization History
- ☐ Last Well Check
- ☐ Partial Records:
  Date Ranges:_____
- ☐ Complete Record
- ☐ Other:
  Please Specify:_____

I understand the information in the medical record may include information regarding the diagnosis and treatment of HIV and other sexually transmitted diseases, drug and alcohol abuse, mental illness, psychiatric treatment, or birth control. I have authorization for these records to be released.

Please send records to Shawnee Mission Pediatrics, P.A. at:

8901 West 74th Street, Suite 10 Shawnee Mission, KS 66204
Phone: (913)362-1660
Fax: (913)362-5916

Patient's Signature (if applicable): _____ **Date:** _____

Parent/Legal Representative's Signature:_____ **Date :**_____