SHAWNEE MISSION PEDIATRICS, P.A.

REQUEST FOR RELEASE OF MEDICAL RECORDS

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

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

Medical Records Request:

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

** Please allow *at least* 2 weeks for COMPLETE RECORDS to be processed. Complete records are MAIL or PICK UP ONLY.**

Purpose of Disclosure:_____

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.

Receipt of Records:

- ☐ I would like to pick up my records in office. Please call _____ when ready.
- ☐ Please send to the following address:_____.
- ☐ Please fax my records to the following number:_____.
- ☐ Please e-mail my records to the following address:_____.

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

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

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