Independence & Lee's Summit PEDIATRICS

Authorization for Obtaining and Disclosing of Patient Health Information

Printed Patient Name:____

Date of Birth:_________________________________

Requesting Provider:____

Provider we are requesting from:____
(Name, Address, and Phone Number of Provider/Facility)

- **I authorize Independence Pediatrics, P.C, "Indep Peds",** to obtain and/or disclose the following health information from my medical record:____
(Describe information, including dates of service, types of conditions or all records)
- I specifically authorize Indep Peds to disclose the types of information selected below:
  - _____ Information relating to care and treatment for Mental Health Conditions/ADHD
  - _____ Information relating to care and treatment for Drug and/or Alcohol Abuse
  - _____ Information relating to HIV testing, Infection Status, or Care for HIV/AIDS
  - _____ Information relating to genetic testing
  - _____ Immunization Records
- The disclosure is for the purpose of:____
(If no purpose is stated, the disclosure is made at my request)
- This authorization expires on the following date or event:____________________________________
(If left blank the authorization will expire 1 year from date signed)
- I understand that I have the right to revoke this authorization at any time, except to the extent that Indep Peds has already acted in reliance of this authorization. I may revoke this authorization by submitting my revocation in writing to Indep Peds at the stated address.
- I understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be subject to protection under Indep Peds' policies and procedures or federal laws protecting the privacy of patient's health information.
- I understand that Indep Peds does not condition my treatment on my signing this authorization and that I may refuse to sign this authorization. However, if Indep Peds is providing healthcare solely to create information for disclosure to the third-party named above, Indep Peds will not provide healthcare unless I sign this authorization.

Patient Signature:____ **Date:_________________________**

If someone other than the patient signs this authorization:

Printed Name:____ Relationship to Patient:___________________________

Legal Guardian_________ Parent;_____________ POA:___________ Other (Please specify):___________________________

Please return to Independence Pediatrics, P.C., Attn: Medical Records Department
4731 S. Cochise Drive, Suite 100, Independence, Missouri 64055
Phone: 816-373-1111 Fax: 816-373-9222