

HAPPY KIDS PEDIATRICS

605 East Main Street Gardner, KS 66030 Phone 913-355-9953 Fax 913-355-9954

Authorization For Release of Patient Health Information

I hereby authorize the release of informa	tion from the me	edical records of:
Patient's Name:		Date of Birth:
Please choose one of the following:		
Patient records will be released from I	Happy Kids Pedi	atrics LLC to
Name:		
Address:		
City:	State:	Zip:
Phone:	Fax: _	
The records will be: Mailed to address above Picked up at Happy Kids Pediatrics by	y the person liste	ed above.
Patient records are to be released to I	Happy Kids Pedi	iatrics LLC from
Practice or Provider Name:		
Address:		
City:	State:	Zip:
Phone:	Fax: _	
The records will be: Mailed to address: 605 East Main St, Faxed to 913-355-9954Other, please specify:		
Information to be Released:Well-visitImmunization recordGrowth Charts		



Entire health record
Records relating to behavioral, developmental and mental health care
Records relating to communicable diseases, HIV or AIDS
Records relating to diagnosis and treatment of alcohol/drug abuse
Other, please specify:
OR I hereby authorize the release of my complete health record with the exception of the following
information:
Mental health records, including behavioral and developmental
Communicable diseases, including HIV and AIDS
Alcohol/drug abuse diagnosis and treatment
Other, please specify:
For dates from to
For dates from to to Mo/Day/Yr
Reason for Release: Specialty care ER visit Hospital admissionContinuity of Care
Other, please specify:
Information
Informed Consent for Release of Confidential Information - The expiration date or expiration event for this authorization is upon delivery of the requested records.
- I understand I have the right to revoke or withdraw the release of medical records as long as the release of records has not taken place, and
have let my revocation/withdrawal be known to Happy Kids Pediatrics in writing and prior to the release. The request to revoke authorization
must contain the signature of the patient, parent, legal guardian or the patient's legal representative - I understand I have the right to review the medical records prior to release from Happy Kids Pediatrics LLC. I understand that by signing this
authorization without the request to review the medical records means I have waived my right to review the medical records that are to be
released by signing this authorization.
- I understand that signing this authorization is completely voluntary, and I have the right to refuse to sign this authorization. The treatment,
payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization. - I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered under Title 4
of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information.
- I understand that the federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patier
- This authorization also includes any information related to diagnosis and/or treatment of any genetic condition, psychiatric or mental illness communicable diseases, and/or any state of infection with the HIV (AIDS) virus.
- I understand that the medical records contain information that only a physician can interpret.
- I understand that I am to consult the physician regarding the contents of the medical record if I have any questions or concerns about the
contents, and that this is to avoid misunderstanding of the contents. - I understand that if I choose not to consult the physician regarding the contents of the medical record, I will not hold Happy Kids Pediatrics I
liable for the misinterpretation of the contents of the medical record.
- Happy Kids Pediatrics LLC hereby is released from all legal liability that may arise from the release of the information requested. Please note
that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected un applicable federal or state laws.
- I understand that any further disclosure or release of the medical records by Happy Kids Pediatrics LLC is prohibited and will require repeat
written consent and authorization, or as permitted by 42 CFR Part 2.
- This authorization covers materials capable of being reduced to printed form.
- The requested records are for only the purpose indicated on this authorization form.
I authorize the use or disclosure of information specified in this authorization regarding the patient nam
above.
Printed Name of Parent, Legal Guardian or Patient (if meeting specific legal criteria)
Signature of Parent, Legal Guardian or Patient (if meeting specific legal criteria)
/ /2023 AM/PM ()
Date: Time: Phone number