



**Authorization to Exchange  
Medical Information  
(Front)**

8071-061 MR 10/06

Patient Name: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Regarding the patient named above, I hereby authorize \_\_\_\_\_ Clinic of The Children's Mercy Hospital to exchange with the individual or facility named below the information specified in this authorization form.

Name of Individual (if applicable): \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

INFORMATION TO BE EXCHANGED (SPECIFY): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\*SEE MEDICAL RECORDS TO RELEASE OR RECEIVE COMPLETE HEALTH RECORD\*\***

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 Medical Records department of The Children's Mercy Hospital or to the individual or organization named above. Unless this authorization is revoked, it will expire one (1) year from the date of signature.

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 the information copied 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 Medical Records department of The Children's Mercy Hospital at (816) 234-3455.

\_\_\_\_\_  
**Signature of Patient/Parent/Legal Guardian** Printed Name/Relationship \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone Number

**MEDICAL RECORDS TO FILE – NO OTHER ACTION REQUIRED**

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(Back)**

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**This authorization complies with policies of The Children's Mercy Hospital that require written authorization to exchange information. This authorization is intended for use throughout Children's Mercy.**

**With any necessary assistance from the initiating staff member, an "authorized" individual (as defined by applicable policies and/or procedures) will complete this form to request the exchange of written and/or verbal medical information between Children's Mercy and outside individuals or facilities.**

**STAFF INSTRUCTIONS:**

1. Assist the patient or parent/legal guardian in completing this form properly and in its entirety.
2. Assure that the patient and parent/legal guardian understand that this authorization is applicable for one (1) year from the date of signature unless they revoke it.
3. Confirm the following:
  - Patient information (name, address, etc.) is complete.
  - Information about the individual/facility exchanging information with CMH is complete.
  - Information to be exchanged is clearly described.
  - The authorizing individual has signed and dated the form.
4. Forward the original to the Medical Records department.
5. Give the yellow copy of the form to the patient/parent/guardian. Inform him/her that he/she is responsible for taking the yellow copy to the individual/facility.