Children's Mercy HOSPITALS & CLINICS

# 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: University Academy

Address: 6801 Holmes Rd

City, State, Zip Code: Kansas City, MO. 64131

Telephone: (816) 412 - 5978 Fax: (816) 302 - 9635

INFORMATION TO BE EXCHANGED (SPECIFY): Sports Physical, immunizations, Asthma Action Plans

**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