



AUTHORIZATION FOR RELEASE OF INFORMATION

Release records TO:

Release records FROM:
Hometown Pediatrics of Joplin
200 Castle Drive
Joplin, MO 64804

I authorize you to furnish a copy of medical records for the below named child/children to the above-named doctor/medical facility. I release you from all legal responsibility or liability that may derive from this authorization. I also understand that I may revoke this authorization at any time, in writing, to the address listed above provided the information has not already been released. This Authorization for Release shall cease to be effective 90 days from this date.

_____	_____
Patient's Name (Print)	Date of Birth
_____	_____
Patient's Name (Print)	Date of Birth
_____	_____
Patient's Name (Print)	Date of Birth
_____	_____
Patient's Name (Print)	Date of Birth

<p>Dates requested: _____ to _____ *if left blank, please send all records</p> <p>Requested Information</p> <p><input checked="" type="checkbox"/> Problem List / <input checked="" type="checkbox"/> Medication List / <input checked="" type="checkbox"/> Vaccines / <input checked="" type="checkbox"/> Lab Studies (within last 90 days)</p> <p><input checked="" type="checkbox"/> Growth Charts / <input checked="" type="checkbox"/> Most Recent Wellness Exam <input checked="" type="checkbox"/> Other: _____</p>	<p>Fax: (417) 626-0600</p> <p>Secure Email: carter.smith@hpjomo.com</p>
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Reason for Record Release or Copy: () Personal copy **<charges may apply>** () Over age 18 () Insurance change
() Moving/changing providers () Referral () Other (Please Specify): _____

Information to be Excluded / Not Released: () Mental Health Records () Drug/Alcohol treatment () HIV Testing
() Sexual Assault/Victimization Records () Other _____

Parent/Legal Guardian Name (Print): _____

Signature: _____ Date: _____
Parent/Legal Guardian