AUTHORIZATION FOR RELEASE OF INFORMATION – PLEASE FAX THE RECORDS

[X] Release records TO:

Hometown Pediatrics of Joplin
200 Castle Drive
Joplin, MO 64804
417-626-0600 FAX

[ ] Release records FROM:

_____
_____
_____

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

Dates requested: _____ ***to*** _____ ****if left blank, please send all records***

Requested Information

Fax: (417) 626-0600
Secure Email: carter.smith@hpjomo.com

__X__ Problem List / __X__ Medication List / __**X**__ **Vaccines** / __X__ Lab Studies

__X__ Growth Charts / __**X**__ **Most Recent Wellness Exam** __X__ Other: _____

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