



AUTHORIZATION FOR RELEASE OF INFORMATION - PLEASE FAX THE RECORDS

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 60 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

***\*Please only send requested information within the last year (except for wellness exam)***

Requested Information

Fax: (417) 626-0600

Secure Email: carter.smith@hpjomo.com

Problem List /  Medication List /  **Vaccines** /  Lab Studies (within last 90 days)

Growth Charts /  **Most Recent Wellness Exam**  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