



Authorization for release of Medical Records to Lawrence Pediatrics

Patient Name: _____ Date of Birth: _____

Requesting Records From (name of previous provider / medical office):

Address: _____

Phone: _____ Fax: _____

Please Send:

☐ **Last physical/well child check, last office visit, problem list, growth chart, and immunizations only**

☐ Other : _____

Medical Records are to be sent to:

Lawrence Pediatrics, PA
3310 Clinton Parkway Court
Lawrence, KS 66047

E-mail: info@lawrencepeds.com

Fax: 785-856-9093 ***PLEASE DO NOT FAX IF RECORD IS OVER 100 PAGES***

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: TRANSFERRING OFFICES

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand the following: See CFR § 164.50(c)(2)(i-iii)

- A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- B. The information released in response to this authorization may be re-disclosed to other parties.
- C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall expire in 90 days.

****There may be a fee charged for copying records.**

Name and Relationship of Legally Authorized Representative to Patient (See 45CFR § 164.508(c)(1)(iv))

Signature of Patient or Legally Authorized Representative (See 45CFR § 164.508(c)(1)(iv))

Date

Witness Signature

Date