PEDIATRIC ASSOCIATES OF SOUTHWEST MISSOURI
2719 E 32ND ST
JOPLIN, MO 64804
PHONE: 417-782-5522 FAX: 833-989-2218

Request for Release of Medical Records TO Pediatric Associates of Southwest Missouri

PATIENT'S NAME:_____ BIRTHDATE:_____

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PATIENT'S NAME:_____ BIRTHDATE:_____

PATIENT'S NAME:_____ BIRTHDATE:_____

PHONE #:_____ ADDRESS:_____

I, THE UNDERSIGNED, AUTHORIZE AND REQUEST,

Name of Previous Physician/Practice: _____

Address:_____

Phone #:_____ Fax#:_____

TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT(S) NAMED ABOVE TO:

Pediatric Associates of Southwest Missouri
2719 E 32nd St
Joplin, MO 64804
Fax: 833-989-2218

THE FOLLOWING INFORMATION FROM MY MEDICAL RECORDS FOR CARE AND TREATMENT RECEIVED FROM:
(date)_____ TO (date)_____.

- O COMPLETE RECORDS
- O CONSULTATION
- O HISTORY & PHYSICAL
- O EKG
- O OPERATIVE REPORTS
- O LABS
- O XRAYS
- O PATHOLOGY REPORTS
- O DRUG/ALCOHOL ABUSE, TREATEMENT, REFERRAL RECORDS
- O MENTAL/BEHAVIORAL HEALTH TREATMENT
- O OTHER (specify):_____

THIS AUTHORIZATION SHALL BE VALID FOR 90 DAYS OR UNTIL _____ AT WHICH TIME IT WILL EXPIRE

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE AUTHORIZATION AT ANY TIME BY SENDING IN WRITTEN NOTIFICATION TO PEDIATRIC ASSOCIATES OF SOUTHWEST MO 2719 E 32ND ST JOPLIN MO 64804 ATTN: MEDICAL RECORDS. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT MY PHYSICIAN HAS RELIED ON THE USE OF DISCLOSURE THE PROTECTED HEALTH INFORMATION ALREADY OR IF MY AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE AND THE INSURER HAS A LEGAL RIGHT TO CONTEST A CLAIM.
I UNDERSTAND THAT INFORMATION USED FOR DISCLOSURE PURSUANT TO THIS AUTHORIZATION MAY BE FURTHER DISCLOSED BY THE RECIPIENT, AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. I UNDERSTAND A PHOTO STATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.
I UNDERSTAND MY PHYSICIAN WILL NOT CONDITION MY TREATMENT, PAYMENT, ENROLLMENT IN A HEALTH PLAN, OR ELIGIBILITY FOR BENEFITS (IF APPLICABLE) ON WHERHER I PROVIDE AUTHORIZATION FOR THE REQUESTED USE OR DISCLOSURE EXCEPT IF MY TREATMENT IS RELATED TO RESEARCH OR HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY.

SIGNED BY:_____ RELATIONSHIP TO PATIENT:_____
DATE:_____ WITNESS:_____