Authorization to Release Health Care Information

Kansas City Pediatric Cardiology Associates
4150 N Mulberry Drive, Suite 150
Kansas City, MO 64116
(816) 584-0505 office
(816-265-6333 fax

Patient's Name:_____ DOB: _____

Parent/Guardian Name: _____

Address: _____

Phone: _____ Cell: _____

I request and authorize *Kansas City Pediatric Cardiology Associates, LLC.* to release healthcare information for the above named patient. Information should be sent to:

Name: _____

Attn: _____ Phone: _____ Fax: _____

Address: _____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
  _____
  _____
- All healthcare information
- Other: _____

_____ Yes _____No *I authorize the release of my STD* results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.*

_____ Yes _____ No *I authorize the release of any records regarding alcohol, drug, or mental health treatment to the person(s) listed above.*

***DEFINITION:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Signature: _____ Date: _____

Relationship to patient if other patient signing: _____

This authorization expires ninety days after it is signed