Authorization to Release Health Care Information

Kansas City Pediatric Cardiology Associates
4150 N Mulberry Dr., Suite 150
Kansas City, MO 64116
816 584-0505 fax 816 265-6333

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Kansas City Pediatric Cardiology

Address: 4150 N. Mulberry Drive, Suite 150

City: Kansas City State: MO Zip Code: 64116

Please fax all information to: 816-265-6333

This request and authorization applies to:

_____Healthcare information relating to the following treatment, condition, or dates: _

_____

_____All healthcare information

_____Other: _____

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.

♦ 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 drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/ Parent Signature: _____ Date Signed: _____

Relationship if other than patient signing: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.