

**Authorization for Use or Disclosure of  
Medical Information  
(Front)**

8071-170 MR 08/07

I authorize the use or disclosure of information specified in this authorization regarding the following individual:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Medical Record Number \_\_\_\_\_

\_\_\_\_\_  
 Prior Name(s) Used \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**1. Release the following information and include dates where appropriate:**

- |   |  |
|---|--|
| <input type="checkbox"/> Pertinent Health Information                 | <input type="checkbox"/> Radiology Reports _____/_____/_____ |
| <input type="checkbox"/> Complete Health Record (includes all visits) | <input type="checkbox"/> Accounting of Disclosures _____     |
| <input type="checkbox"/> Visit History                                | <input type="checkbox"/> HIV Test Results _____              |
| <input type="checkbox"/> Emergency Room Visit _____/_____/_____       | <input type="checkbox"/> Alcohol and Drug Information _____  |
| <input type="checkbox"/> Outpatient Visit _____/_____/_____           | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Immunizations _____/_____/_____              | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Test Results _____/_____/_____               |  |

**2. Purpose for which this information is to be used:**  At the request of the individual  Transfer of medical care

- Doctor Appointment: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ at \_\_\_\_\_ Doctor's Office Fax Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Other Ongoing Treatment or Care: \_\_\_\_\_
- Other (specify): \_\_\_\_\_

**3. Information to be RELEASED BY:**

- Organization: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Attention: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**4. Information to be SENT TO:**

- Organization: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Attention: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Medical Records department of The Children's Mercy Hospital or to the other organization named. Unless this authorization is revoked, it will expire once the disclosure is complete.

I do not need to sign a specific authorization to disclose information for treatment, payment or health care operations. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have the information copied to be used or disclosed. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have questions about disclosure of my information, I can contact the Medical Records department of The Children's Mercy Hospital at (816) 234-3455.

\_\_\_\_\_  
 Printed Name of Patient, Parent or Legal Guardian \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Signature of Patient, Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone Number \_\_\_\_\_

**STAFF USE ONLY:**  Information Released as Authorized: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

## Authorization for Use or Disclosure of Medical Information (Back)

8071-170 MR 08/07

### STAFF USE ONLY:

This consent complies with policies of The Children's Mercy Hospital that require written consent to exchange information. This consent is intended for use throughout Children's Mercy.

With any necessary assistance from the initiating staff member, an "authorized" individual (as defined by applicable policies and/or procedures) will complete this form to request the release of medical information from The Children's Mercy Hospital to an outside person or facility, OR from an outside person or facility to The Children's Mercy Hospital.

### STAFF INSTRUCTIONS:

1. Assist the patient and parent/legal guardian as necessary in completing this form properly and in its entirety.
2. Assure that the patient and parent/legal guardian understand that this consent is applicable until the disclosure is complete, unless they revoke it sooner.
3. Confirm the following:
  - Patient information (name, address, etc.) is complete.
  - The appropriate items for release have been checked.
  - Purpose for information is explained.
  - It is clear who is to release and who is to receive information – appropriate boxes are checked and location and/or person are specified in the appropriate blank(s). (This will determine how consent is processed – see #4 below.)
  - The authorizing individual has signed and dated the consent.
4. If information is to be released from an outside agency or person to The Children's Mercy Hospital, the parent/legal guardian will keep the completed form (or may take the blank form home to complete). He or she is responsible for taking the original to the outside agency or person. (A copy will typically be sent with any information released to The Children's Mercy Hospital.
5. If information is to be released by The Children's Mercy Hospital, give the parent/legal guardian the yellow copy of the completed form. If necessary, he or she will make that copy available to the outside agency or person receiving information. He or she will take necessary action, and sign and date the bottom of the front page. (The Medical Records department will file the original in the medical record.
6. Follow up as needed in your department and document according to applicable policies and procedures.

### The Children's Mercy Hospital Locations

(Place ID in appropriate blank for #3 or #4 on front.)

<u>ID</u>	<u>Location</u>	<u>Address</u>	<u>Telephone #</u>
<b>MR</b>	Medical Records Department	2401 Gillham Road, Kansas City, MO 64108-4619	(816) 234-3455 FAX: (816) 234-3458
<b>NOR</b>	Children's Mercy Northland	501 NW Barry Road, Kansas City, MO 64155-2732	(816) 413-2500
<b>SOU</b>	Children's Mercy South	5808 West 110 <sup>th</sup> Street, Overland Park, KS 66211-2504	(913) 696-8000 FAX: (913) 696-8260
<b>SPC</b>	CMH Specialty Center	5808 West 110 <sup>th</sup> Street, Overland Park, KS 66211-2504	(913) 696-8220 FAX: (913) 696-8260
<b>PPO</b>	Children's Mercy West / The Cordell Meeks Jr. Clinic	4313 State Avenue, Kansas City, KS 66102	(913) 233-4400 FAX: (913) 287-0132
<b>CMHC</b>	Children's Mercy Home Care	1900 West 47 <sup>th</sup> Place, Suite 330, Westwood, KS 66205-1802	(913) 696-8999
<b>SCHSC</b>	Children's Mercy South Hearing & Speech Clinic	5520 College Blvd., Suite 360, Overland Park, KS 66211-1630	(913) 696-8844
<b>DEV</b>	CMH Section of Developmental & Behavioral Sciences	2401 Gillham Road, Kansas City, MO 64108-4619	(816) 234-3674
<b>CARE</b>	CMH CARE Clinic	2401 Gillham Road, Kansas City, MO 64108-4619	(816) 234-3424
<b>SCCAR</b>	Children's Mercy South Cardiology Clinic	5520 College Blvd., Suite 360, Overland Park, KS 66211-1630	(913) 696-8700

**\*\*IF LOCATION OR PERSON IS NOT LISTED, SPECIFY IN BLANK PROVIDED ON FRONT.**