Children's Mercy

Authorization for Release of Medical Information to Children's Mercy

8071-195 MR 05/18

Patient's Full Name and Previous Names Used | Date of Birth | Medical Record Number

Street Address | City | State | Zip Code

Information to be Released – Check all that apply.

- ☐ Pertinent Health Information*
- ☒ Complete Health Record** (includes all visits and information on record)
- ☐ Visit History Only
- ☐ Immunization Record
- ☐ Emergency department (ER or ED) visit on (date): / /
- ☐ Outpatient visit on this date: / /
- ☐ Test results for this date: / /
- ☒ Radiology Reports
- ☒ Radiology Images
- ☒ Cardiology Images (including EEG, EKG)
- ☐ HIV Test Results
- ☐ Alcohol and Drug Information
- ☐ All Information for This Date Range:
- ☒ Other: Genetic Testing Results

Information will be RELEASED BY – Complete all fields.

Organization:

Telephone Number: Fax Number: ( ) –

Street Address | City | State | Zip Code

Release information by: ☐ Mail delivery ☐ Fax ☐ CD/DVD, if available ☐ Email, if available

Purpose of Release – Check all that apply.

- ☐ Doctor appointment on (date): / / Location:
- ☐ Other ongoing treatment or care:
- ☒ Other: Genomic Answers for Kids Research Study

Send Information to the following – Complete all fields.

Organization and/or Name: Children's Mercy Hospital, Center for Pediatric Genomic Medicine, Genomic Answers for Kids Study

Telephone Number: 816-915-4200 Fax Number: 816-302-9927

Street Address	City	State	Zip Code
2420 Pershing Avenue, Suite 410, Attn: Genomic Answers for Kids	Kansas City	Missouri	64108

I authorize the use or disclosure of information specified in this authorization regarding the patient named above. 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 Health Information Management 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 copied the information 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 Health Information Management department of The Children's Mercy Hospital at (816) 234-3455.

Printed Name of Patient, Parent, or Legal Guardian | Relationship to Patient | ( ) – Telephone Number

Signature of Patient, Parent, or Legal Guardian | / / Date

Street Address (if different from above) | City | State | Zip Code