Pediatric Orthopaedic Surgery Associates
5250 West 94th Terrace
Prairie Village, KS 66207
913-451-0000 FAX 913-491-0547

REQUEST FOR RELEASE OF INFORMATION

Date: _____ Phone number: _____

Patient Name PRINT: _____ Patient Date of Birth: _____

I AUTHORIZE RELEASE OF MEDICAL RECORDS

TO: Pediatric Orthopaedic Surgery Associates
5250 West 94th Terrace, Prairie Village, KS 66207 913-451-0000 FAX 913-491-0547

FROM: _____
Facility Name

_____
Address

_____ Phone: _____ FAX: _____
City, State, Zip code

FROM: _____
Facility Name

_____
Address

_____ Phone: _____ FAX: _____
City, State, Zip code

☐ I AUTHORIZE RELEASE OF MEDICAL RECORDS **TO MYSELF/LEGAL GUARDIAN** to be:

- □ **Mailed** Address: _____
- □ **Faxed** Fax number: _____
- □ **Picked up** Pick up Day: _____
- □ **Secure e-mail** Secure e-mail address: _____

☐ I AUTHORIZE RELEASE OF MEDICAL RECORDS **FROM Pediatric Orthopaedic Surgery Associates:**

TO: _____
_____
_____
Phone: _____ FAX: _____

RECORDS TO BE RELEASED:

- □ ALL: Copy of complete medical records
- □ History and Physical(s)
- □ Operative Report(s)
- □ Discharge Summary(s)
- □ Progress note(s)
- □ Lab test results(s)
- □ Radiology Report
- □ Radiology Disk(s) ONLY PICK UP OR MAIL
- □ Other:
  _____
  _____

The facility, its employees, officers, and attending physician(s) are released from legal responsibility or liability for the release of information to the extent indicated and authorization herein. This authorization shall be valid for a period of one year unless a lesser time frame is indicated.

_____ _____
Signature of Parent/guardian Relationship

_____ _____
Signature of witness Date