TENNEY
Pediatrics & Adolescents
Advancing Pediatric Care

6501 East 87th Street
Kansas City, MO 64138
PH: (816) 444-8400 – FX: (816) 444-8407

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

- This consent to release information about a patient is intended to satisfy the requirements of Kansas, Missouri, and federal law. I understand that my child's medical record includes information pertaining to all aspects of my child's healthcare. I give my specific authorization for these records to be released.
- I understand that the information released here may no longer be protected by federal privacy regulation and may be subject to re-disclosure.

Patient Name: _____ **DOB**: _____ SSN: _____
Address: _____ City/State: _____ Zip: _____

I, the undersigned, hereby authorize our Previous Medical Office:
Name: _____
Address: _____ City/State: _____ Zip: _____
Primary Phone: (_____) _____ Email: _____

To release to TENNEY PEDIATRIC & ADOLESCENT MEDICINE, the following information pertaining to my medical care (check applicable):

[ ] Complete Medical Record (including: immunization records, growth charts, sick/well visits, lab reports, ordered x-rays, etc)
[ ] Basic Medical Record (Immunization records, sick/well visit summaries)
[ ] Immunization Records Only
[ ] Other (please specify) _____
_____

This authorization shall be valid for (6) years. I hereby release Tenney Pediatrics from any and all legal responsibility or liability that may arise from the above actions authorized by myself.

X _____ date: _____
Parent, Legal Guardian, or Legal Representative

Relationship to Patient _____