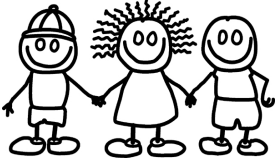


Johnson County Pediatrics  
 8800 West 75<sup>th</sup> Street, Suite 220  
 Shawnee Mission, KS 66204  
 Phone:913.384.5500 Fax: 913.384.5209



**Authorization for Release of Medical Records**

|               |                |
|---------------|----------------|
| Patient Name: | Date of Birth: |
| Patient Name: | Date of Birth: |
| Patient Name: | Date of Birth: |
| Patient Name: | Date of Birth: |

Purpose of Release: \_\_\_\_\_

If leaving the practice, please state reason: \_\_\_\_\_

|  |   |   |  |
|--|---|---|--|
| Please place an "X" on all that apply:                                 |   | <b>***** PLEASE ONLY MARK ONE (1)*****</b>                |  |
| <input type="checkbox"/> Complete Chart -<br>\$18.00 plus .60 per page | <input type="checkbox"/> Date range Only ___/___/___ TO ___/___/___ | <input type="checkbox"/> Office Visits only/Partial Chart | <input type="checkbox"/> Immunizations/Last well exam/Growth Chart<br>\$5.00 Fee for these three (3) Items |

By requesting Medical Records, I understand and agree that I am financially responsible for the applicable fees per the Kansas State Law. Medical records requests will be processed once payment is received.

\_\_\_\_\_  
 Signature of Parent/Legal Guardian (if under 18 yrs of age) \_\_\_\_\_  
 Date

Name of Individual picking up records **OR** Mail records to the following address:

\_\_\_\_\_  
 Picture ID required \_\_\_\_\_

\_\_\_\_\_  
 Daytime Telephone \_\_\_\_\_

|                             |  |                     |
|-----------------------------|--|---------------------|
| Date request received:      |  |                     |
| Date payment received:      |  | Cash or Credit only |
| Date records copied:        |  |                     |
| Date records mailed/pick up |  | Initials:           |