

**Priority Care Pediatrics, LLC**  
9411 N. Oak Trafficway, Suite 210  
Kansas City, MO 64155-2262  
(816) 412-2900

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

This authorization permits use and/or disclosure of the following individually identifiable health information about me or my child:

To/From: Dr. \_\_\_\_\_  
Priority Care Pediatrics, LLC  
9411 N. Oak Trafficway, Suite 210  
Kansas City, MO 64155-2262  
(816) 412-2900 – Office (816) 412-2915 – Fax

Please Circle  
To or From

**These records should be released:**

To/From: Dr. \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone & Fax: \_\_\_\_\_

- Records to be released:**  Immunization Record  Growth Chart  Laboratory/X-ray reports  
 Complete Medical Records including immunization data and other physician reports  
 Consultant/Other Physician Reports  Mental Health Information  HIV/AIDS test results

**Dates:**  All  \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

**Authorization Expiration Date** (1yr unless noted): \_\_\_ / \_\_\_ / \_\_\_

NOTE: Release is authorized  
ONLY for those items  
checked

**The information released will be used for the following purpose:**

- At the patient/guardian's request  Other: \_\_\_\_\_

I do not have to sign this authorization in order to receive treatment from Priority Care Pediatrics, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address for Priority Care Pediatrics above.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

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Print Name of Patient or Legal Guardian Signing Above

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Today's Date