

CHILD CARE LIMITED
RELEASE OF RECORDS AUTHORIZATION
1004 Carondelet Drive, #350; Kansas City, MO 64114
Telephone (816) 942-8644 Fax (816) 942-7066

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

From: _____

I hereby request that my medical records be released to:

Child Care Limited
Attn: Medical Records
1004 Carondelet Drive, Suite 350
Kansas City, MO 64114

_____ Records regarding treatment for the following medical condition or injury
_____ on or about _____ (date).

_____ Entire medical record; no limitations placed on dates, history, or illness, or
diagnostic and therapeutic information. (Including any special services,
records and treatment for alcohol and/or drug abuse.)

Patient and/or parent, guardian, or authorized representative must initial this
authorization. _____

_____ Records for the period from _____ to _____.

Dated this _____ day of _____, 20_____.

(Witness)

X _____
(Patient or Guardian)

Patient(s) Name: _____ DOB _____

***Please be informed that records transferred to this office from another physician, hospital, or other treatment center can not be released by this office.