PAX COMMUNITY HEALTH
1625 NW O'Brien Lee's Summit, MO 64081

# Medical Records Release

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|---|---|---|
| First Name and Middle Initial: | | Last Name: |
| Street Address: | | |
| City: | State: | Zip: |
| Phone Number: | | Social Security Number (last 4 digits): |
| Birthdate (mm/dd/yyyy): | | Medical Record Number: |

**I, _____ (Patient's PRINTED full name)**

**authorize PAX Community Health Clinic to release the following medical and/or dental information to:**

**_____for the purpose of CONTINUITY OF CARE .**
**(Clinic name and phone and/or fax of where we are to send records to)**

Please initial the appropriate selection:

____ **ALL** of my medical/dental records (as of the date of this release)

I wish to **EXCLUDE** the following (**initial to EXCLUDE** or ALL will be requested/sent):

____ Any record of treatment for alcohol and/or other substance abuse
____ Any record of mental health treatment
____ Any record of testing, treatment, reporting, or research pertaining to infection with HIV, any sexually transmitted or related disease, or pregnancy termination

____ All of my medical/dental records ***except the following***:_____

____ *Only* the following information: _____

This release is effective for one year from the date of execution; however, I may revoke it at any time by providing notice in writing to the above named party. I acknowledge receiving a completed copy of this release.
A copy of this form is acceptable authorization for the release of the above described information.

**Notices to Person Authorizing Disclosure**

*Except for certain research purposes, the completion of this authorization is not required prior to the provision of treatment. The information released pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.*

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|---|
| Printed Name: |
| Signature: |
| Relationship to patient (circle one): Patient/Self Parent Legal Guardian Other: |
| Date: |