Children's Mercy HOSPITALS & CLINICS

Authorization to Exchange Information with Community Resources (Front)

8071-183 MR 12/08

Patient Name _____ Date of Birth / / _____ Medical Record Number _____

Prior Name(s) Used _____

Street Address _____ City _____ State _____ Zip _____

I authorize The Children's Mercy Hospital to exchange with the agencies checked below, verbally, in writing, or via electronic media, the information specified in this authorization regarding the individual named above.

- ☐ BCBS Caring Program for Children
  2301 Main Street, Kansas City, MO 64108
  (816) 395-2222
- ☐ Missouri State Board of Education
  PO Box 480, Jefferson City, MO 65102
  (573) 751-4212
- ☐ Kansas State Department of Education
  120 SE 10th Avenue, Topeka, KS 66612
  (785) 296-3201
- ☐ Love Fund
  3030 Summit, Kansas City, MO 64108
  (816) 753-4567
- ☐ MAAC (Mid America Assistance Coalition)
  One West Armour Blvd, Suite 20, Kansas City, MO 64111
  (816) 561-3339
- ☐ First Hand Foundation
  2800 Rockcreek Parkway, Kansas City, MO 64117
  (816) 221-1024
- ☐ Legal Aid of Western Missouri
  1125 Grand Blvd, Suite 1900, Kansas City, MO 64106
  (816) 474-6750
- ☐ Ronald McDonald House
  2501 Cherry, Kansas City, MO 64108
  (816) 842-8321
- ☐ Social Security Administration
  (800) 772-1213
- ☐ Salvation Army
  3637 Broadway, Kansas City, MO 64111
  (816) 756-1455
- ☐ Don Bosco
  531 Garfield, Kansas City, MO 64124
  (816) 691-2900
- ☐ *Division of Family Services
  221 West High Street, PO Box 1527, Jefferson City, MO 65102
  (573) 751-4815
- ☐ *Kansas Social & Rehabilitation Services
  500 SW Van Buren, Topeka, KS 66601
  (785) 296-2500

☐ Agency: _____ Address: _____ Phone: (_____) _____ - _____
☐ Agency: _____ Address: _____ Phone: (_____) _____ - _____
☐ Agency: _____ Address: _____ Phone: (_____) _____ - _____
☐ Agency: _____ Address: _____ Phone: (_____) _____ - _____
☐ Agency: _____ Address: _____ Phone: (_____) _____ - _____
☐ Agency: _____ Address: _____ Phone: (_____) _____ - _____

INFORMATION TO BE RELEASED/PURPOSE: _____

SEE MEDICAL RECORDS TO RELEASE OR RECEIVE COMPLETE HEALTH RECORD

I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Medical Records department of The Children's Mercy Hospital or to the other organization named. Unless this authorization is revoked, it will expire one year from the date of signature.

I do not need to sign a specific authorization to disclose information for treatment, payment or health care operations. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have questions about disclosure of my information, I can contact the Medical Records department of The Children's Mercy Hospital at (816) 234-3455.

Printed Name of Patient, Parent or Legal Guardian _____

Signature of Patient, Parent or Legal Guardian _____ Date / / _____ Relationship to Patient _____

Street Address _____ City _____ State _____ Zip _____ Telephone Number ( ) -

MEDICAL RECORDS TO SCAN – NO OTHER ACTION REQUIRED

Children's Mercy HOSPITALS & CLINICS

Authorization to Exchange Information with Community Resources (Back)

8071-183 MR 12/08

STAFF USE ONLY:

This authorization complies with policies of The Children's Mercy Hospital that require written authorization to exchange information. This authorization is intended for use throughout Children's Mercy.

With any necessary assistance from the initiating staff member, an "authorized" individual (as defined by applicable policies and/or procedures) will complete this form to request the exchange of written and/or verbal medical information between The Children's Mercy Hospital and outside facilities.

STAFF INSTRUCTIONS:

1. Assist the patient and parent/legal guardian as necessary in completing this form properly and in its entirety.
2. Assure that the patient and parent/legal guardian understand that this authorization is applicable for one (1) year from the date of signature, unless they revoke it sooner.
3. Confirm the following:
   - ☐ Patient information (name, address, etc.) is complete.
   - ☐ Facility information is complete.
   - ☐ Information to be exchanged is clearly described.
   - ☐ The authorizing individual has signed and dated the authorization.
4. Forward the original to the Medical Records department.
5. Give the yellow copy to the patient, parent, or legal guardian and inform that individual that he/she is responsible for taking it to the applicable facility or facilities.

NOTE: No authorization is needed for initial hotline, participation in the investigative process, or related case information for up to 90 days. Documentation of disclosure is needed.