REQUEST FOR RELEASE OF RECORDS

I authorize _____ to release all medical records for the following patient(s):

Name: _____ Date of Birth: _____

_____

Street address City State Zip

Dr Joel P Karasek MD PC
3955 Sherman Avenue
St. Joseph, MO 64506
Phone: (816) 232-6601
Fax: (816) 232-6606

I understand that without this authorization, the provider would not be permitted to disclose this information, as indicated by law.
This disclosure of my child's medical records to Dr Joel P Karasek MD, PC is requested to aid in the ongoing medical care of my child.
If my child's health or billing records contain information about drug or alcohol abuse, mental health illness or sexually transmitted disease or other sensitive information, I also agree to its release ☐ Yes ☐ No
I recognize that I may revoke this authorization at any time (except to the extent that the information has already been released in reliance of this form) by submitting a written notice to Dr Joel P Karasek MD PC at the above address. If not revoked, this consent will expire on year from the date signed.
I agree further not to sue or hold the provider of the information, its employees or agents, responsible for any issues, claims or causes of action arising out of the release of information in conformance with the terms of this release.

Signature of Patient or Personal Representative

_____ Date: _____

Identity of requestor verified via: ☐ Photo ID ☐ Matching signature
☐ Other (specify) _____

Verified by: _____ Title _____