Patient Name: _____

D.O.B.: ___/___/_____ MRN: _____

Children's Mercy

Authorization for Release of Medical & Educational Information (Page 1 of 2)

8071-412 MR 05/24

_____

Street Address City State Zip Code

I consent to the release or exchange of this information: Check all that apply.

	➡ Information the School may share with Children's Mercy
	Current schoolwork
	Individual Educational Plan (IEP) or other learning accommodations
	Section 504 plan
	Behavior plan
	Current grades / test scores / transcript
	Curriculum guide / syllabus
	Emotion / behavior / symptom screeners
	Other (please specify):

	➡ Information Children's Mercy may share with the School
	Record of instruction or materials used and work completed
	Recommended modifications or accommodations for the patient
	Instructional strategies
	Log of instructional sessions
	Action Plans (e.g., asthma, diabetes, catheterization action plans)
	Orders (e.g., medications, nutrition/diet, trach suctioning)
	Activity/sports restrictions or clearance
	Pertinent medical information (e.g., progress notes, tests results, reports, discharge summaries)
	Other (please specify):

I understand that this information may include information or records regarding mental health, alcohol, and/or drug abuse or treatment, HIV/AIDS test results, and/or other communicable diseases. I understand that the information may be released orally or in written or electronic form (such as by secure email). It may also include information created in the past, present, or future up to the expiration or my revocation of this Authorization.

Purpose of the release or exchange of information: Check all that apply.

	Academic support by Hospital Based School Program
	Ongoing instructional needs
	Ongoing assessment of academic, behavioral, and/or functional progress
	Other:

Who may the information be released to at the School: Complete all fields.

School	
Staff Member Name(s)	
E-mail or phone number(s)	
Fax	

Who may the information be released to at Children's Mercy: Complete all fields.

Organization	*Children's Mercy*
Staff Member Name(s)	
E-mail or phone numbers(s)	
Fax	

Revocation:

I approve the release or exchange of information specified in this Authorization regarding the patient named above. I understand I have the right to revoke this Authorization at any time. Such revocation will not apply to information that has already been released in response to this Authorization. To revoke this Authorization, I must give written notice to the Health Information Management department at Children's Mercy and to the school named above. I understand that once information is put into the Children's Mercy medical record, Children's Mercy is not required to remove any information from the record, even if I revoke this Authorization.

Patient Name: _____

D.O.B.: ____/____/_____ MRN: _____

Children's Mercy

Authorization for Release of Medical & Educational Information (Page 2 of 2)

8071-412 MR 05/24

Expiration: Check which one applies.
Unless this Authorization is revoked, it will expire:

☐ Once the disclosure is complete
☐ Once the services are complete
☐ End of school year

Assurance: I understand that approving the release of this information is voluntary. I do not need to sign this form in order to assure treatment, payment, or eligibility for services at Children's Mercy. I know I can refuse to sign this Authorization. Children's Mercy may deny requests for access to protected information under federal or state law. I understand that information disclosed pursuant to this Authorization carries the potential for unauthorized redisclosure. If this protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may lose privacy protections. Children's Mercy and the school would no longer be able to keep it confidential. If I have questions about disclosures of health information, I can contact the Health Information Management department of The Children's Mercy Hospital at (816) 234-3455 or ROI@cmh.edu.

_____	_____	(___)_____-_____
Printed Name of Patient, Parent or Guardian	Relationship to Patient	Telephone Number

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

_____			
Street Address (if different from above)	City	State	Zip Code

If signed by an individual other than a parent, please describe your authority to act on behalf of the patient (*supporting legal documents granting authority must accompany this Authorization if not previously provided*):

Return completed form via fax to (816) 701-4034, in person, or by mail at:
Children's Mercy Health Information Management
2401 Gillham Road
Kansas City, MO 64108

CM Staff: Return completed ROI to HIM via fax (816) 701-4034 or ROI@cmh.edu.