HIGH RISK Pregnancy CENTER OF KANSAS CITY

1201 NW Briarcliff Parkway
Suite 310
Kansas City, MO 64116
816-541-2700
877-670-9432 (fax)

Consent Form to Release/Receive Medical Records

Date: _____

☐ Please release my medical records to: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

☐ I authorize High Risk Pregnancy Center of Kansas City to receive my medical records from:

_____

Address: _____

_____

Phone Number: _____

Fax Number: _____

I hereby authorize the selected above to either release or receive my medical records including office notes, x-rays, operative reports, and any information regarding medical consultations and treatment, I have received.

Patient's First and Last Name: _____

DOB: _____ Social Security Number: _____

_____

Patient or Guardian's Signature