Kosair Charities
Authorization for Release of Medical Information

Patient's Full Name Birthdate

I give Kosair Charities permission to release and/or request medical records on the above-named patient, and I hereby declare that I am the legal guardian of the above-named patient.

Kosair Charities has my permission to release medical records and information to doctors and other hospitals of facilities needing it for diagnostic and treatment purposes. I do not object to Kosair Charities releasing the needed information by mail or fax. I am aware that my medical records or those of my ward may include information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

Kosair Charities may request information (any information received will be kept confidential) form:

Name of person/institution to send or release information

Address

I understand that I may revoke this consent at any time; however, said revocation cannot be applied retroactively after the information has been released in good faith.

Parent/Guardian Signature Date