**Medical Records Release Form**

By signing the form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to Margaret’s Place LLC.

Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information you may release subject to this signed release form is as follows:**

Complete Records

Care Plan

Pathology Reports

Hospital Reports

History & Physical

Lab Reports

Treatment Record

Medication Records

Progress Notes

Radiology Reports

Operative Reports

Other: Please Specify

**Release my protected health information to:**

Margaret’s Place LLC | Adult Recreation and Wellness Center | 7217 Troost Ave Kansas City, Mo 64131

The purpose for the release of information is Adult Day Care enrollment, care plan, treatment, goal setting and participant wellness planning.

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Participant Signature Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Representative Print Name Date