

Authorization for Release of Hospital Records

IN THE DISTRICT COURT OF _____ COUNTY, KANSAS

In the Matter of the Adoption of:

Case No. _____

(CHILD'S NAME)

Date of Birth. _____

AUTHORIZATION FOR RELEASE OF HOSPITAL RECORDS

COMES NOW, _____, Kansas Department for Children and Families
(DCF) Regional Director for the _____ Region, and advises all parties herein as follows:

1. I am the DCF Regional Director for the _____ Region; I am authorized by the Secretary of the Kansas Department for Children and Families to consent to the adoption herein and executed this authorization for release of information.
2. The DCF Secretary is the custodian of _____ (Full name of CHILD), born on _____ (date of birth) at _____ (name and address of hospital or medical center). Said child may be or has been subject to a name change at the time of adoption; the party requesting records can supplement this Authorization with the final decree of adoption verifying a change of name, if any.
3. A consent to adoption of the above-named child has been executed.
4. Pursuant to K.S.A. 59-2130, a properly executed authorization for release of any hospital records pertaining to the child named above shall be filed with the petition for adoption of the child.
5. As an authorized representative for the custodian of the minor child, I hereby give permission to the following persons to request and receive the complete health/hospital records/information pertaining to the child named above, including but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions from any provider named above or any provider discovered by such persons after the time of signature of this release who may not be listed above who can be verified to have

provided services to the above captioned minor child:

- Adoptive parent(s)
- Attorney(s) for the adoptive parent(s)
- Interstate Compact of Placement of Children Administrators involved in adoption matter
- Court in connection with adoption case, as necessary

6. This authorization to share health/medical records is valid for records created from the time of the child's birth until the date of finalization of the child's adoption pursuant to a decree of adoption filed in the adoption matter for all persons named in paragraph 5. hereinabove except the Adoptive parent(s) for whom the Authorization remains valid.

7. I authorize this information to be shared in either hard copy form or through any electronic means including access through a secured web based portal.

8. This release of information is intended to meet all requirements of HIPAA Privacy Rule 45 CFR §164.500-534.

Regional Director

ACKNOWLEDGEMENT BEFORE NOTARIAL OFFICER

State of Kansas)
)
County of)

I, a notarial officer in and for the County and State aforesaid, certify that _____, Regional Director of DCF _____ Region Office, known to me to be the same person whose name is subscribed to the foregoing authorization appeared before me in person and acknowledged that the statements made in the foregoing document are true and correct.

_____ at _____ .M.
Date Time

My Appointment expires:

Notary Public