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	History & Physical	Progress Notes
Care Plan	Lab Reports	Radiology Reports
Pathology Reports	Treatment Record	Operative Reports
Hospital Reports	Medication Records	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.

_____		_____
Participant Signature	Print Name	Date
_____		_____
Authorized Representative	Print Name	Date