AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

Full Name of Patient: _____

Maiden Name/Alias: _____

Patient's Birth Date: _____Social Security Number: _____

INFORMATION REQUESTED (X): ( ) Complete Medical Record ( ) Portion of Medical Record*

*If only a portion of the medical record is required please specify:

INFORMATION REQUESTED FROM:

Provider/Facility:_____

Street Address_____

City/State/Zip: _____Fax Number: _____

THE ABOVE RECORD IS TO BE RELEASED TO:

Name/Facility: _____

Street Address: _____

City/State/Zip: _____Fax Number: _____

THE RECORD IS REQUESTED FOR THE FOLLOWING REASON (X) :

( ) Continued Medical Care ( ) New Primary Care Physician ( ) Insurance Purposes

( ) Personal Interest ( ) Legal Purposes ( ) Other (Specify)_____

The authorization must be signed and dated and may be revoked by notifying Meade County Pediatrics mentioned above in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 90 days after the date below or sooner by my choice, in which case this consent will expire on the date or event _____. Such expiration date or event has not occurred.

REQUEST FOR RECORD COPY RELEASE WILL BE HANDLED ON A FIRST COME, FIRST SERVE BASIS.

( ) Kentucky Law directs health care providers to furnish to a patient, at the patient's request, one free copy of the patient's Medical Record. *Free copies exclude copies of x-ray films, video tapes or color photographs and a separate fee will be assessed if these items are requested.*

( )Additional requests for copies will be charged a rate of $1.00 per page.

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal and/or state law. Federal and state regulations prohibit you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Signature:_____ Date:_____
Patient, Parent or Legally Authorized Representative

Social Security Number:_____Phone Number: _____

FOR INTERNAL OFFICE USE ONLY:

Date Authorization Received:_____Date Records Sent:_____

Name of Person Sending Records :_____