PEDIATRIC ASSOCIATES
1717 HIGH STREET SUITE 3A
HOPKINSVILLE KY 42240
PHONE (270) 885-8445 ~~ FAX (270) 886-9106

Authorization to Release Medical Records/Information

IMPORTANT: PLEASE FILL OUT EVERY LINE IN FULL WITHIN THE SHADED AREA

Fax #: ____________

FULL NAME of Physician providing records:______________________________________**Phone #:** ___________

Street: ____

City: ____**State:** ___________ **ZIP:**_________________

Patient's name:____**DOB:**______________________

Your Current Phone Number: ____

Person/facility (full name) to receive records:____**Phone #:** ___________

Address:____

City, State, Zip:____

REASON FOR TRANSFER/COPYING OF RECORDS____

____

READ CAREFULLY BEFORE SIGNING:

If you are transferring a patient's records to another local physician please let it be called to your attention that this patient may not be able to be seen in our office effective the date of transfer.

ALL MILITARY PERSONNEL:

If you are a Military person and are *TEMPORARILY* being transferred to another location, please write (MILITARY MOVE) on this form for the reason for transfer of records.

Please check the specific protected health information that is to be disclosed to Pediatric Associates	*Initials*
1. Only records generated by this facility (not including records received from other sources)	______
2. Only some portion of records maintained at facility (dates of treatment, etc, specify below)	______
3. All medical records at this facility	_______

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.
I authorize the heath care provider to release the information specified to the organization, agency or individual named on this request with the **EXCEPTION** of:

INITIALS INITIALS

________ Substance abuse, if any ________AIDS/HIV, if any

________Psychological or psychiatric conditions, if any

Other (Please Specify)____

Expiration or revocation of authorization ó I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after date affixed above.
Use of copies ó A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name	**Person authorized to sign for patient:**
______________________________	______________________________
Please Print	**Please Print**
______________________________	______________________________
Relationship to patient (Please print)	**Signature**
Date:_________________________	**Date:**_________________________