INCOMING

Commonwealth Pediatrics
1780 Nicholasville Road, Suite 301
Lexington, KY 40503
Phone: 859-277-6636
Fax: 859-277-1455

PATIENT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

The purpose of this form is to obtain authorization for use or release of confidential health care information. This includes any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

I, _____, AUTHORIZE _____
Patient or Parent/Legal Guardian — Name of Individual, Practice, or Entity

_____
Address

_____
City/State/Zip Code

_____
Telephone

TO RELEASE MEDICAL RECORDS ON THE FOLLOWING PATIENTS:

Patient Name(s): _____ Date(s) of Birth: _____
_____ _____
_____ _____
_____ _____

To: **COMMONWEALTH PEDIATRICS, PSC**
1780 NICHOLASVILLE ROAD, SUITE 301
LEXINGTON, KY 40503

Purpose:
□ Transferring care: _____
□ Moving/Relocating (New Address): _____
□ Personal Use

This request and authorization applies to:
□ All medical records
□ Health care information relating to the following treatment, condition, or dates of treatment: _____
□ Specific records to be released (eg. Labs, imaging reports, other):
_____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____
Signature of Patient or Authorized Representative — Date

_____ _____
Print Name — Relationship to Patient

THIS AUTHORIZATION **EXPIRES 30 DAYS FROM DATE OF SIGNED REQUEST**