OUTGOING

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

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize **Commonwealth Pediatrics**, its physicians, employees and agents to release or disclose to the below-named recipient, all of my medical records. 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.

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

_____ _____

_____ _____

_____ _____

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

_____
Address

_____
City/State/Zip Code

_____
Telephone

Purpose of disclosure (check applicable):

□ Transferring care: _____

□ Relocating (New Address): _____

□ Personal Use

This authorization is good for electronic, disc, and paper releases.

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**