KAPLAN BARRON PEDIATRICS

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENTS'S MEDICAL RECORDS:

Patient Name: _____ Date of Birth: _____

Street Address: _____ Phone number: _____

City, State: _____ Zip Code: _____

The above record is to be released to:

Name/Title/Practice: _____

Street Address: _____

City/State/Zip: _____**Phone #: _____**

Reason for Request: ☐ Continued Medical Care ☐Personal Copy ☐ Legal Purposes ☐Insurance Purposes

☐ Adult Doctor ☐ Moving ☐ Leaving practice ☐ Other: _____

Delivery Method: (Select One) ☐ Electronic-Intelichart ☐ Mail - USPS

INFORMATION REQUESTED:

Type of information: ☐ Itemized Bills ☐ Medical Record ☐ Psychiatric Report ☐ Complete Medical Record

Specific Records: If only a portion of the record is required, please specify below:

☐ History & Physical ☐ Immunization Records ☐ Progress Notes

☐ HIV/STD Test ☐ Mental Health Records ☐ Drug/Alcohol Treatment

☐ Sexual Assault/Victimization Records ☐ Other _____

***Release or Copy requests expire 60 days from signature date. *Please allow 30 days for processing**

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. 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 condition, 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 disclosures of the medical record for the purpose and extent stated above.

If Kaplan Barron Pediatrics is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under this authorization.

Signature _____ Date _____

Patient, Parent or Legally Authorized Representative

Relationship to the Patient: _____ Phone #: _____