Kaplan Barron Pediatrics

Authorization to Disclose Protected Health Information (PHI)

I hereby request a copy of the following patient's medical records:

Patient Name: _____Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Records to be Released To

Name / Title / Practice: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Reason for Request *(Check one)*

☐ Continued Medical Care ☐ Personal Copy ☐ Legal Purposes
☐ Insurance Purposes ☐ Transitioning to Adult Doctor ☐ Moving
☐ Leaving Practice

If leaving the practice, reason for leaving:

Delivery Method *(Select one)*

☐ Electronic ☐ Mail (USPS)

Information Requested *(Check all that apply)*

☐ Itemized Bills ☐ Medical Record ☐ Psychiatric Report ☐ Complete Medical Record

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Specific Records Requested

If only a portion of the medical record is required, please specify below *(check all that apply)*:

☐ _____

Expiration and Processing Time

Release or copy requests expire **60 days** from the signature date.
Please allow **up to 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 at a rate of **$1.00 per page**.

Authorization and Acknowledgment

I understand that the medical record released pursuant to this authorization may contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which may be subject to federal and/or state restrictions on disclosure.

I understand that if the person or entity receiving 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 may no longer be 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.

If Kaplan Barron Pediatrics is requesting to use or disclose my information, I understand that I may refuse to sign this authorization and that my refusal 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 or disclosed under this authorization.

Signature: _____Date: _____

Relationship to Patient: _____