Physicians to Children & Adolescents
201 South Fifth St.
Bardstown, KY 40004
Phone: 502-348-6309
Fax: 502-348-2793

Physicians to Children & Adolescents
102 W. Depot St.
Springfield, KY 40069
Phone: 859-336-3952
Fax: 859-336-3953

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

An individual may request their personal medical record or the medical record of a person they legally represent. A person requesting the medical records of a minor must have legal custody. If applicable legal documentation is required.

Patient's Name: _____
DOB:_____
Social Security #: _____

Information Requested:

☐ **Entire Medical Record**

☐

☐ **Only Specified Information: _____**

Information Requested From:

Name/Facility: _____
Street Address: _____
City/State/Zip: _____
Phone:_____ Fax:_____

Information Requested for the Following Reasons:

☐ **New Primary Care Physician**
☐ **Continued Medical Care (Ex: Specialist)**
☐ **Insurance Purposed**
☐ **Legal Purposes**
☐ **Personal Interest**
☐ **Other: _____**

Information Released To:

Physicians to Children & Adolescents
201 South Fifth St.
Bardstown, KY 40004 or

I understand this authorization is good for 180 days unless otherwise specified. I am aware that if the person or entity that receives this information is not a healthcare provider or plan covered by federal privacy regulations, this information may be re disclosed and no longer be protected by these regulations. I understand I have the right to revoke this authorization in writing. Furthermore, per 94 HC250, I am entitled to one free copy of my medical record. Additional requests will be charged 1.00 per page. Patients obtaining their medical record for personal use must present in person with picture identification.

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

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.

Parent/Legal Guardian Printed Name:_____ Patients Printed Named:_____
Parent/Legal Guardian Signature:_____ Patients Signature: _____

Date:_____ Contact Phone Number:_____

For internal office use only: Date authorization received: _____ Date sent:_____