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: [Patient->Full Name]
DOB: [Patient->Date Of Birth]
Social Security #: [Patient->SSN]

Information Requested:

☐ **Entire Medical Record (** ***If you wish to receive information from other medical facilities, there will be a charge of 1.00 per page.)***
Please check below if you wish to receive and pay for other facility records.

☐

☐ **Only Specified Information: _____**

Information Requested From:
Physicians to Children & Adolescents
201 South Fifth St.
Bardstown, KY 40004

Information Requested for the Following Reasons:

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

Information Released To:

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

Please check whether you wish to pick up or have your medical records mailed.

☐ **I choose to pick up my medical records.** ***(Please be advised medical records may take up to 30 days, our office will notify you once complete. Once you are notified that you can pick up records, you will be given 30 days to pick up. If records are not picked up within 30 days, records will be destroyed and counted as your free copy.***

☐ **I choose to have my medical records mailed to the address above.**

I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure, my protected health information, used and/or shared under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to redisclose. Additionally, I understand that my information prohibits the recipient to further disclose any information without written consent unless otherwise permitted by Federal Law 42 CFR Part 2.

I understand this authorization is good for 1 year 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:_____