Owensboro Pediatrics
2200 East Parrish Ave Building B Suite 101
Owensboro, KY 42303
Phone: 270.683.3232
Fax: 270.926.0760

Patient Authorization for Practice to Release Protected Health Information

Patient Name: _____Date of Birth: _____

Street Address: _____City: _____ST: _____Zip: _____

Phone Number: _____ Fax Number: _____

This authorizes Owensboro Pediatrics to_____ release OR _____receive a copy of my medical record to _____use OR _____disclose to or from the following:

_____

_____

(INCLUDE ACCURATE AND COMPLETE NAME AND ADDRESS OF INDIVIDUAL OR ENTITY RECEIVING RECORDS OR WHERE RECORDS ARE COMING FROM. INCOMPLETE INFORMATION WILL NOT BE PROCESSED.) Please include phone # and fax # of entity.

Requested Format:
_____Paper Copy
_____Fax
_____CD
_____*EHI Export (Disclaimer: this option transmits in computer jargon and may be illegible to read)*

PURPOSE OF RELEASE:

_____Send all medical records to Owensboro Pediatrics
_____Leaving Owensboro Pediatrics for new Pediatrician/Physician
_____Moving out of town
_____Other _____

This authorization will expire on _____
(List a specific date, time period, or event)

AUTHORIZATION:
I, the above-named patient (parent if minor) release any and all information that I may have concerning past or present psychiatric, psychological, history of alcohol use, drug abuse, or HIV/AIDS testing results, any and all medical records.
I understand that my records are protected under the FEDERAL CONFIDENTIALITY REGULATIONS and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expired within 120 days from the date of the signature below.

_____ _____
Signature of Patient, Legal Guardian or Power of Attorney Date

_____ _____
Signature of Witness Date