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MEDICAL RECORDS AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This form authorizes Pediatric Partners of NKY to use and/or disclose protected health information in the manner described below and is voluntary. PPNKY will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to re-disclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations. Pediatric Partners will not condition treatment, payment, enrollment or eligibility for benefits of the execution of this Authorization.

PATIENT FULL NAME ____DOB____________
____DOB____________
____DOB____________
____DOB____________
____DOB____________
ADDRESS____

AUTHORIZES RELEASE OF RECORDS

	TO: (where the records are going)	FROM: (who has the records now)
HEALTH CARE FACILITY	______________________	______________________
STREET ADDRESS	______________________	______________________
CITY, STATE, ZIP	______________________	______________________

INFORMATION TO BE RELEASED: (All records will be released in an electronic format unless otherwise requested.)

___ENTIRE MEDICAL RECORD
___IMMUNIZATION RECORDS
___LABORATORY REPORTS
___RADIOLOGY REPORTS
___HOSPITALIZATION REPORTS
___OTHER ______________________________

PURPOSE OR NEED FOR DISCLOSURE: Transferring out of Pediatric Partners of NKY? ☐ yes ☐ no

___Moving
___Insurance change
___Personal copy
___Legal
___School
___Age of child
___Other ______________________________

I UNDERSTAND THAT IS AUTHORIZATION SHALL BE VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE.

I AUTHORIZE RELEASE OF MY CHILD'S MEDICAL INFORMATION IN ACCORDANCE WITH THE SPECIFICATIONS LISTED ABOVE. I UNDERSTAND WRITTEN NOTICE IS NECESSARY TO CANCEL THIS REQUEST.

I ALSO UNDERSTAND THAT THE HEALTH INFORMATION THAT MAY BE DISCLOSED INCLUDES ANY INFORMATION CONCERNING HIV TESTING AND THE TREATMENT OF AIDS, AIDS RELATED CONDITIONS, DRUG OR ALCOHOL ABUSE, DRUG RELATED CONDITIONS, AND/OR PSYCHIATRIC PSYCHOLOGICAL CONDITIONS.

SIGNATURE OF
PARENT/GUARDIAN/SELF:______________________________________DATE_________

LEGAL AUTHORITY IS: ____PARENT____LEGAL GUARDIAN____OTHER (SPECIFY)________________