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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 \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

**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.)

<input type="checkbox"/> ENTIRE MEDICAL RECORD	<input type="checkbox"/> RADIOLOGY REPORTS
<input type="checkbox"/> IMMUNIZATION RECORDS	<input type="checkbox"/> HOSPITALIZATION REPORTS
<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> OTHER _____

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

<input type="checkbox"/> Moving	<input type="checkbox"/> Legal	<input type="checkbox"/> Other _____
<input type="checkbox"/> Insurance change	<input type="checkbox"/> School	PLEASE TELL US WHY YOU ARE LEAVING
<input type="checkbox"/> Personal copy	<input type="checkbox"/> Age of child	

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) \_\_\_\_\_