HIPAA AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO: CORNER PEDIATRICS, PSC * 2505 LARKIN DRIVE SUITE 103 * LEXINGTON, KY 40503

PHONE: (859) 600-1999 * FAX: (859) 600-1998

Patient Information

Child's Name and DOB: _____

Child's Name and DOB: _____

If needed, please continue the children's names and birthdates on the other side of this form.

Complete Address Including Zip Code: _____

_____

Phone: _____

Release FROM

Name of Physician or Practice: _____

Complete Address with Zip Code: _____

_____

Phone: _____ Fax: _____

Information to Release

☐ Entire Medical Record ☐ Immunizations Only ☐ Other, please specify: _____

Dates of Treatment Requested: _____

Purpose of Release

☐ Continuity of Care ☐Legal ☐ School ☐ Personal Use ☐ Insurance

☐ Other: _____

Parent/Legal Guardian/Patients ≥ 18 Years of Age

This authorization expires one year from the date of signature, OR on this date/event: _____.
I understand that treatment does not depend on me signing this Authorization. I understand that these medical records might have information about sexually transmitted disease including HIV/AIDS. They might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, or other health-related organization, these records may no longer be protected by the Federal Privacy Regulations, and this person or organization might release the records to someone else. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer of Corner Pediatrics, PSC, at the above address.

By signing below, I affirm that I am the patient or patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

_____

Signature of Parent/Guardian/or Adult Patient Date Printed Name