BROWNSBORO PARK PEDIATRICS

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AUTHORIZATION TO REALEASE MEDICAL INFORMATION
(PLEASE ALLOW OUR RECORDS DEPARTMENT 1-2 WEEKS TO PREPARE YOUR RECORDS REQUEST)
BY LAW, THE PRACTICE HAS 30 DAYS TO RELEASE RECORDS

I hereby authorize the release of my medical records:
TO/FROM (CIRCLE ONE) Brownsboro Park Pediatrics
6002 Brownsboro Park Blvd, Suite C
Louisville KY 40207

RELEASE TO/FROM: (CIRCLE ONE) **Name/Facility**____________________

Address____________________

City__________ **State**__________ **Zip Code**__________

Phone Number__________ **Fax Number** __________

Patient (s) Information:

Name__________ **Date of Birth** __________

Name__________ **Date of Birth** __________

Name__________ **Date of Birth** __________

RECORDS REQUESTED: Dates of Service (Please indicate dates) __________

Entire Medical Record ______ **Other** (Please specify) __________

FORMAT: USB ______ **CD**______ **PAPER**______

As required by Health Insurance Portability and Accountability Act (HIPPA) of 1996, we may not use or disclose your health information except as provided in our Notice of Privacy without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure described previously.

***This authorization shall not be valid for greater than one year from date of signature.**
***I understand I may revoke the authorization at any time by requesting such of the above reference clinic in writing.**
***Under State Law, individuals are entitled to ONE FREE copy of their medical records. Additional copies will be provided for $1 per page and $25 flat rate for USB AND CD along with the cost of postage.**

Patient Signature/Legal Representative (If under 18 yrs. of age) __________

Printed Name and Relationship to Patient __________

Today's Date__________ **Records Needed By Date**__________