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UNION, KY 41091
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Today's Date: _____

Printed Name of Patient

Date of Birth

Address: _____
Street Address

City, State

Zip Code

Phone Number

X _____
Signature of Patient/Patient's Representative

Relationship to Patient

Expiration Date/90 days

X _____
Signature of Witness

I hereby authorize the use and disclosure (release) of my Medical Record Information:

From: _____

To: _____

The records to be released includes: Entire Medical Record; Other: _____

Medical Records will be used and/or disclosed for the following purpose:

At the request of the individual Changing Primary Care Physician Other: _____

I acknowledge and agree that the Medical Records Information may include notes by the physicians and staff of Union Pediatrics, test results, reports, correspondence, x-rays as well as claims, billing and payment information. I authorize the use/disclosure of info. concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded. Medical records that were created and transferred to Union Pediatrics by another physician will not be released unless specifically requested.

Please EXCLUDE the following information, if it is part of my Medical Record Information:

Chemical Dependency/Substance Abuse Psychiatric/Psychological Conditions
 Sexually Transmitted Diseases Drugs Alcohol N/A

I understand that this authorization shall remain in effect for a period of 90 days. I further understand that I may revoke this authorization at any time by notifying Union Pediatrics in writing; however, if I choose to do so, I understand that my revocation will not affect any actions taken by Union Pediatrics before receiving my revocation.

I am designating _____ to pick up my Medical Records.

A PHOTO ID WILL BE REQUIRED TO PICK UP MEDICAL RECORDS