8667 US HWY 42, SUITE 300
UNION, KY 41091
PHONE: (859) 384-2550
FAX: (859) 384-0947

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 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