BROWNSBORO PARK PEDIATRICS

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

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: ______**Entire Medical Record** _____**Billing** ______**Other** ____________

FORMAT: _____**Paper** _____**CD**

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 disclosures 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 referenced clinic in writing.**
***Under State Law, individuals are entitles to ONE FREE copy of their medical records. Additional copies will be provided for $1.00 per page plus mailing cost.**

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

Printed Name and Relationship to Patient__________________________

Today's Date ________________ **Records Needed By**____________________

Infants • Children • Adoloesents