PEDIATRIC CARE OF KENTUCKY, P.S.C.
AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I, ______________________________________, hereby authorize **Pediatric Care of Kentucky, P.S.C,** (the "Practice") to release all medical records and information, whether oral or written, including, but not limited to treatment notes, visit history, lab reports, diagnostic evaluations, outpatient records, films of x-rays, MRIs or PET scans, genetic testing, and prescription records concerning any medical treatment or evaluations that I have received from the Practice, including all such records of other medical providers in the possession of the Practice. This authorization (please check)

☐includes or ☐does not include

information on STD, birth control, pregnancy, alcohol, other drug abuse or addiction, to:

Name: ______________________________________ Relationship: ____________________

The purpose of this authorization is to permit the above-named individual(s) to receive information related to my medical care to keep such individuals informed of my health care because they are involved in my care or treatment, to obtain payment on my behalf, and it is my request that they have such medical information.

A photocopy of this Authorization shall be as valid as the original authorization.

This authorization, unless revoked earlier, shall remain in effect until I am no longer a patient of the Practice. I understand that I have the right to revoke this authorization at any time except to the extent the Practice has already acted upon it as a result of this authorization. I further understand that any revocation must be provided in writing to Pediatric Care of Kentucky attention Privacy Officer.

I understand that I have the right to refuse to sign this authorization and that the Practice will not condition treatment on the provision of this authorization.

I also understand that when information is used or disclosed based on an authorization; the information may be re-disclosed by the recipient and no longer protected by HIPAA.

By my signature below, I acknowledge receipt of a signed copy of this authorization.

______________________________________ ______________________________
Signature of Patient or Legal Representative Date

____
If signed by the Patient's Legal Representative, please provide a description of Legal Representative's authority to act on behalf of the patient

Patient's DOB: ______________________ Patient's SSN: ______________________

4-10-13