

PEDIATRIC CARE OF KENTUCKY, P.S.C.

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AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS 10-19-15

Per a patient's **written request**, medical records will be copied at **no charge** for first time requests. Thereafter, a copying fee of \$1.00 per page (per KRS 422.317(1) will be assessed. Please call our Medical Records Clerk for the exact amount.

Please list below the Patient(s) Name, Address, Date of Birth and Home Phone of records to be transferred:

Patient Name	Address/City/State/Zip	D.O.B.	Phone#

Medical records are being requested for the following reason:

- Age Insurance Relocation Specialist Visit
 Dissatisfaction** Other

** If you are transferring records to another health care provider, please state below the reason(s) for your change.

I understand this release may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse. I also understand that HIV, AIDS, or AIDS-related information may also be released.

▪ **PLEASE RELEASE THE ABOVE INFORMATION TO:** _____

▪ **PICK UP RECORDS: PHONE #** _____

 Physician/Parent/Patient/Legal Guardian

 Signature of Parent/Patient/Legal Guardian Date

 Address

 Print Name of Signature Above

 City/State/Zip

 Signature of Witness Date