Poole & Thomas
personal pediatric care

2351 Huguenard Drive, Suite 200
Lexington, KY 40503
(859) 260-7700 Phone
(859) 260-7797 Fax
www.ptpediatrics.com

REQUEST FOR RELEASE OF MEDICAL RECORDS

The purpose of this form is to obtain authorization for use or release of protected health care information. Patients have the right to receive one free copy of their medical records. There will be a charge for any additional requests.

I, ____, authorize the entity listed below to release medical records for the following patients.

PLEASE DO NOT FAX MEDICAL RECORDS

PATIENT INFORMATION:

Name: ____ DOB: _____________________________

Name: ____ DOB: _____________________________

Name: ____ DOB: _____________________________

Name: ____ DOB: _____________________________

Records From:	**Records To:**
____ Doctor or Group Name	____ Doctor or Group Name
____ Mailing Address	____ Mailing Address
____ City, State & Zip Code	____ City, State & Zip Code
____ Phone Number & Fax Number	____ Phone Number & Fax Number

INFORMATION REQUESTED:

_______ All health care information, including all mental health records.

_______ All Immunization Dates and Growth Charts

_______ Health care information relating to the following treatment, condition, or date of treatment:

____

_______ Other: ____

For the purpose of: __________ Transfer of Care __________ For Specialist Visit __________ Moving or Relocation

I hereby request and authorize the release of requested health care information from the above named party to the corresponding above named party. This authorization will expire 60 days from the date signed. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Poole and Thomas Pediatrics.

____ ____

Signature of Patient or Legal Guardian Date

____ ____

Printed Name of Patient or Guardian Relation to Patient