PEDIATRIC ASSOCIATES OF ELIZABETHTOWN
111 Helmwood Plaza Drive, Elizabethtown, KY 42701
Phone: (270) 737-4808 Fax: (270) 737-4939

AUTHORIZATION FORM

ALL PARTS OF THIS FORM MUST BE FILLED OUT IN ORDER TO SUBMIT YOUR REQUEST.

I authorize Pediatric Associates to use and disclose a copy of the specific health information described below regarding:

Name of Patient:_____ Date of Birth: ____/____/____

Obtain records from: _____ (or ☐ Pediatric Associates)
Address: _____
_____

Send records to: _____
Address: _____
_____

For the purpose of: *(check one)*

☐ obtaining records for continuity of care ☐ referral to specialist
☐ transfer of records to another physician ☐ other:_____

Description of records to disclose: *(check one)*

☐ notes on these dates _____ or regarding _____ diagnosis/injury
☐ entire medical record, including notes, labs, x-rays, hospital dictations, immunizations, growth curve, and correspondence
☐ immunizations only ☐ school physical and immunizations only

Expiration date or event:_____ (ex. one month)

Please note that the patient has the right to revoke the authorization in writing unless records have already been disclosed. Information given to others may be redisclosed by the recipient and no longer protected by privacy regulations. Send requests to revoke to our privacy officer, Melissa B. Flynn, M.D., in writing. Our practice may not condition treatment or payment on whether the authorization is signed.

Pediatric Associates will supply one free copy of records but will charge one dollar per page for any additional copies.
I may have a copy of this authorization if desired. *(Check one)*
☐ I do not request a copy. ☐ I have been given a copy.

_____ _____/_____/_____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient and Personal Representative Description of Authority (i.e. parent)