PEDIATRIC ASSOCIATES OF ELIZABETHTOWN, PLLC
111 Helmwood Plaza Drive, Elizabethtown, KY 42701
Phone: (270) 737-4808 Fax (270) 737-0421 / (270) 737-4939

RECORDS REQUEST AUTHORIZATION FORM

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

I authorize Pediatric Associates of Elizabethtown 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 of Elizabethtown)**

Address:_____

_____

Send records to:_____

Address:_____

_____

For the purpose of: (*check one*)

☐ Obtaining records for continuity of care ☐ referral to specialist ☐ other:_____

☐ transferring out of practice - Reason:_____

_____

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 record 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 disclosed again by the recipient and no longer protected by the privacy regulations. Send written requests to revoke to our privacy officer, Melissa B. Flynn, M.D. Our practice may not condition treatment or payment on whether the authorization is signed.

Pediatric Associates of Elizabethtown will provide **one free copy of records. Additional copies will be charged at one dollar per page.**

I may have a copy of this authorization if desired. (*check one*) ☐ I do **not** request a copy ☐ I **do** request a copy

_____ _____

Name of Patient or Representative (*print*) Description of Representative (i.e. parent/guardian)

_____ ____/____/____

Signature of Patient or Representative Date