

AUTHORITY TO RELEASE RECORDS

I, _____ give my permission for the office of: *(check one box)*

OR

Pediatric Associates, PSC
2865 Chancellor Drive
Suite 225
Crestview Hills, KY 41017
(859) 341-5400 (phone)
(859) 578-3172 (fax)

To release my child(ren)'s complete medical records to: *(check one box)*

Pediatric Associates, PSC
2865 Chancellor Drive
Suite 225
Crestview Hills, KY 41017

OR

Transferring **out** of Pediatric Associates? yes no

Reason for release:

- Moved in/out of geographic area
- Health insurance change
- Age of child
- Referral

Information to release:

- Entire Medical Record
- Records for date range _____
- Records related to _____
- Other: _____

Child(ren)'s names and birth dates:

Parent/Guardian name, address and phone number:

Signature of Parent/Guardian

Date

- Only requested information will be sent. Information is kept confidential and used only for medical reference only.
- Each patient is entitled to one copy of his or her medical records at no charge. Additional copies will be provided with a charge of .50 per page.
- This authorization will expire 90 days from when signed.

Pediatric Associates Authorization

Date