OLDHAM COUNTY PEDIATRICS, PLLC

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REQUEST FOR MEDICAL RECORDS

Patient name: _____
(Last) (First) (MI)

Date of Birth:_____ SS#_____

Date of Request:_____

Requesting medical records from: _____

_____

_____

_____

I hereby authorize you to release my medical records to Oldham County Pediatrics. This information may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing. My written revocation must be submitted to the Privacy Officer at Oldham County Pediatrics. I understand this request is valid for one year from the date of my signature.

Signature:_____ Date:_____