OLDHAM COUNTY PEDIATRICS, PLLC

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REQUEST FOR MEDICAL RECORDS

This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV and AIDS related conditions.

Patient Name:____

(Last)   (First)   (MI)

Date of Birth:____________________________ **Today's Date**:__________________________

Requesting medical records from:____

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I hearby authorize you to release my medical records to Oldham County Pediatrics, PLLC. 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 writing 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:______________________