ONE pediatrics℠

RELEASE OF INFORMATION

4171 Westport Road
Louisville, KY 40207
(502) 896-8868 Fax: (502) 95-6278

6112 Crestwood Station
Crestwood, KY 40014
(502) 896-8868 Fax: (502) 95-6278

I hereby authorize East Louisville Pediatrics, PSC to release my child/children's protected health information to:

Name of Physician/Entity: _____ Phone #: _____

Address: _____

Parent/Guardian Name(s): _____

Name of Child/Children:	Date of Birth:	Year Last Seen:
_____	_____	_____
_____	_____	_____
_____	_____	_____

These Records will be disclosed for the following reason(s):

- ☐ Insurance change (New insurance is _____)
- ☐ Moving or need to be closer to home
- ☐ Child nearing 18 (if ALREADY 18 OR OLDER, MUST SIGN OWN RELEASE)
- ☐ Legal Purposes
- ☐ Other

The Minimum records necessary include:

- ☐ Immunizations with dates
- ☐ treatment/correspondence from _____ to _____ (dates).
- ☐ ENTIRE MEDICAL RECORD

I understand that I can revoke this authorization, in writing, at any time by sending written notification to the above named practice. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my child/children's protected health information.

Print name of Parent or Legal Guardian:	Date:	Phone Number:
_____	_____	_____

Signature:	Relationship:
_____	_____