East Louisville Pediatrics

4171 Westport Road
Louisville, KY 40207
Office: 502-896-8868
Fax: 502-895-6278

6112 Crestwood Station
Crestwood, KY 40014
Office: 502-896-8868
Fax: 502-241-6906

RELEASE OF INFORMATION

I hereby authorize East Louisville Pediatrics, PSC to release a copy of my child's medical records.

Parent/Guardian Name(s): _____

Electronically sending to Email Address: _____

Name of Child: 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's protected health information.

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

_____

Signature: Relationship:

_____

Markus E. Laney, M.D., F.A.A.P.
Robert A. Belza, M.D., F.A.A.P.
Jessica L. Holloman, M.D., F.A.A.P.
Nina Leigh, ARNP
Lacy Ochs, M.D., F.A.A.P.
Kara B. Sammons, M.D., F.A.A.P.
Michael Bricken, M.D., F.A.A.P.
Stephanie C. Lynch, M.D., F.A.A.P.
Michelle MacDavid, M.D., F.A.A.P.
Cecilia Finch, ARNP

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REQUEST FOR RELEASE OF MEDICAL RECORDS

I authorize East Louisville Pediatrics, PSC to furnish a copy of the medical records of:

Name of Child _____

Date of Birth _____

I realize that the physicians of East Louisville Pediatrics, PSC consider the continuity of care extremely import. For this reason, I understand and agree, that once care is transferred to another local practitioner, I will be considered to have permanently severed my professional relationship with East Louisville Pediatrics, PSC, and the child shown above will not be accepted back as a patient of East Louisville Pediatrics, PSC in the future.

I also understand that these medical records are furnished to me at no cost in compliance with Kentucky state law. There will be a charge for any additional copies of the medical records provided for the above-named patient.

_____

Parent/Guardian Signature Date

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Questionnaire for patient's that are transferring in town.

The medical record request for _____is being processed. East Louisville Pediatrics appreciates you for allowing us to be a part of your family's medical care. To provide excellent patient care and satisfaction we would value your opinion on the services we have rendered.

Reason for transfer: _____

1. Did you have any issues with scheduling well checkups or sick visits?

2. Was our staff courteous and helpful?

3. Was the billing department helpful in explaining balance due and insurance benefits?

4. Any suggestions on area's we could improve?

5. Would you recommend our practice to others?

Practice transferring to: _____