FUTURE HOPE PEDIATRICS

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AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Please have my physician send the following information: (mark all that apply)

Complete Record	▫	Consults/Specialist Records	▫	Progress Notes	▫
Health & PE	▫	Shot Record	▫	Labs	▫

Complete Records are those of Future Hope Pediatrics physicians only.

I,_____, certify the above request is accurate and hereby authorize the release of indicated health records (protected) from Future Hope Pediatrics to:

Name of Individual or Practice: _____

Address: _____

Phone: _____

Fax: _____

By signing below, you acknowledge the following: I understand that I can revoke this authorization, in writing, at any time by sending a 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 the 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.
I understand that Kentucky law states that upon patient's written request, a healthcare provider shall provide, without charge to the patient, a copy of the patient's medical record. A copying fee, not to exceed one dollar per page, may be charged by the health care provider for furnishing a second copy of the patient's medical record upon request either by the patient or the patient's attorney, or the patient's authorized representative.
I have read and understand the above statement and consent to the release of all Medical Records.

Printed Name of Parent/Legal Guardian: _____

Signature: _____ **Date:** _____