Poole and Thomas Pediatrics, PLC
2351 Huguenard Drive, Suite 200
Lexington, KY 40503
Phone: 859-260-7700
Fax: 859-260-7797

Patient Authorization for Use/Release of Health Care Information

(Records Coming In to Poole and Thomas Pediatrics)

The purpose of this form is to obtain authorization for use or release of confidential health care information.

Please DO NOT fax records.

You can email this completed form to: jgiles@ptpediatrics.com

I, _____, authorize: _____

Parent or Legal Guardian — Name of individual of entity

Address: _____

City/State, Zip: _____

Phone and Fax: _____

to release medical records on the following patients:

Patient name: _____ Date of Birth: _____

_____ _____

_____ _____

_____ _____

to **Poole and Thomas Pediatrics, PLC**
2351 Huguenard Drive, Suite 200
Lexington, KY 40503

for the purpose of:
Transfer of all records _____
Moving/Relocating _____
Other health care information (please specify): _____
_____

_____ _____

Signature of Patient or Legal Guardian — Date

_____ _____

Print Name of Patient or Legal Guardian — Relationship to Patient

THIS AUTHORIZATION **EXPIRES 30 DAYS FROM DATE OF SIGNED REQUEST**