AUTHORIZATION FOR RELEASE OF INFORMATION
Records Request from Other Providers

Must be completed for all authorizations
I hereby authorize the use or disclosure of my health information as described below.

Patient Name: _____ D.O.B.: ___/___/___ Patient Name: _____ D.O.B.: ___/___/___

Patient Name: _____ D.O.B.: ___/___/___ Patient Name: _____ D.O.B.: ___/___/___

I authorize _____

_____

_____ to release all medical information to Pediatric & Adolescent Associates, PSC at 3050 Harrodsburg Road, Lexington, KY 40503.

This authorization permits Pediatric & Adolescent Associates to use and/or disclose the following individually identifiable health information about me: **(Please initial by each item.)**

All Medical Records for all dates of service. _____

Release any information on HIV testing, AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, and/or psychiatric/psychological conditions. _____

Other: _____

For transfer of care to PAA. (If any other reason, please list below.)

_____

I do not have to sign this authorization in order to receive treatment form Pediatric & Adolescent Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 3050 Harrodsburg Road, Lexington, KY 40503.

I understand that this authorization will expire within 30 days of date authorizing or with the following event:

_____

_____ _____ _____
Signature of Patient or Legal Guardian Print name Date

_____
Relationship to the Patient