A Caring Touch Pediatrics
Newborn through Young Adult

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Lexington, KY 40509
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REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION: **PLEASE PRINT:**

NAME _____

DOB: _____ Current Phone No: _____

RECORDS FROM:	**RECORDS TO:**
_____ MD or Group Name	_____ MD or Group Name
_____ Mailing Address	_____ Mailing Address
_____ City, State & Zip Code	_____ City, State & Zip Code
_____ Phone Number/ Fax Number	_____ Phone Number/ Fax Number

INFORMATION REQUESTED:

_____ All Medical Records for all of patient's visits

_____ Other (please describe) _____

_____

I hereby request and authorize the release of requested health care information from the above named party to the corresponding above named party. This authorization will expire three months from the date signed. 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 A
Caring Touch Pediatrics.

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations (HIPAA).

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed Name of Patient or Guardian Relation to Patient