**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Printed Name of Patient Date of Birth Today’s Date

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Street Address City State Zip Phone

×\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature of Patient or Patient’s Representative Relationship to Patient

**I hereby authorize the use and disclosure (release) of my medical records:** (check one box)□From □To □From □To

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Northern KY Pediatric Group, PSC
 Attn: Medical Records

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1016 Town Drive
 Wilder, KY 41076
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 859-441-7600 (phone)
 ***RECORDS MUST BE MAILED***

Transferring **out** of Northern KY Pediatric Group? □ yes □ no
 **Reason for release: Information to release:**□ Moved in/out of geographic area □ Entire Medical Record
□ Health insurance change □ Records for date range \_\_\_\_\_\_\_\_\_\_\_\_
□ Age of child □ Records related to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
□ Referral □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please include the following information, if it is part of my medical record information.
□ Sexually Transmitted Diseases □ Alcohol □ Drugs □ Chemical dependency/substance abuse □ Psychiatric/psychological conditions

I understand that this Authorization shall remain in effect for a period of 90 days. I further understand that I may revoke this Authorization at any time by notifying NKPG in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by NKPG before receiving my revocation.

* Only requested information will be sent. Information is kept confidential and used only for medical reference only.
* Each patient is entitled to one copy of his/her records at no charge. There will be a $1.00 per page charge for additional copies or “lost or misplaced” records.
* Once a patient is transferred out, we will not accept them back unless the transfer was due to “relocation”. Please allow for 7 to 14 days for processing.

Refusal to sign this authorization in no way affects my treatment, payment, or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Northern KY Pediatric Group Authorization Expiration Date or 90 days*