Louisville Pediatric Specialists
Medical Records Release/Request Form

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Email:info@loupeds.com

Patient Authorization for Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your individually identifiable health information without your authorization, except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the use and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

I hereby authorize,_____("Authorized Party") to release health information on the patient named below:

Patient Name (print)_____ **Date of Birth** _____

Patient Name (print)_____ **Date of Birth** _____

Patient Name (print)_____ **Date of Birth** _____

Relationship to Patient:_____ **Telephone** _____

Address _____ **City/State** _____ **Zip** _____

I Authorize the Release Of:

- ☐ **ALL** my health information maintained ☐ Include Previous Provider Records
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s):_____ ☐ Other: _____

Reason For Release (must be noted): _____

Please select method of delivery

_____ Mail ____ Pick up ____ Fax

Send/Release Medical Records To:_____ **Address** _____

City _____ **State** _____ **Zip** _____ **Phone** _____ **Fax** _____

RESTRICTIONS: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse.

PLEASE Check ALL Requested Exclusions: □Alcohol/Drug □Behavior/Mental Health/Psychiatric □Sexually Transmitted Disease

□HIV/AIDS □Other; specify exclusion ___

I understand that I have the right to request that a service for which I have paid out---of---pocket, not be disclosed to my health plan.

This authorization will terminate (check one):

☐ - Upon sending a written revocation to the Authorized Party.

☐ - On the following date: _____, 20____.

☐ - Other: _____

SIGNATURE: _____ **PRINT NAME:** _____ **DATE:** _____

Patient /Guardian/Parent/Patient's Representative

RELATIONSHIP TO PATIENT: _____

Guardian/Parent/Personal Representative

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REFUSAL TO SIGN AUTHORIZATION: I understand that I have the right to refuse to sign this authorization. I understand that by declining to sign this form, my medical (healthcare) treatment and insurance benefits will not be affected, however, my medical records **CANNOT** be released. I understand that I may revoke this authorization at any time by notifying the organization in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by HIPAA. However, other state or Federal laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.