Request for Medical Records

Today's Date ____________________

Previous Physician ____________________
Address ____________________
City ____________________ State ____________________ Zip ____________________
Phone ____________________
Fax ____________________

Patient(s) covered by this request:

Full Name ____________________ DOB ____________________
Full Name ____________________ DOB ____________________
Full Name ____________________ DOB ____________________
Full Name ____________________ DOB ____________________

If charts are over 25 pages please mail, do not fax

As the undersigned and legal guardian of the above named patient(s), I hereby authorize the release of medical records to Prospect Pediatrics. I understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to revoke this authorization in writing at any time. This request is valid for one year from the date of my signature.

Signature ____________________ Date ____________________

Relationship to Patient ____________________

Prospect Pediatrics
9217 U.S. Highway 42
Prospect, KY 40059
502-228-1312

ONE Pediatrics, PLLC: All Star Pediatrics, Pediatrics of Bullitt County, East Louisville Pediatrics, Prospect Pediatrics, South Louisville Pediatrics, Springs Pediatrics, Kaplan Barron Pediatric Group, Oldham County Pediatrics, and Growing Kids Pediatrics.

POS Reorder # 1701027