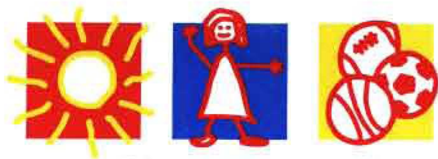

mt. sterling pediatrics

MEDICAL RECORD RELEASE AUTHORIZATION

TO: ____

(Practice name/phone number)

I hereby request the medical records on

______________________________________ ________________

(Patient's Name) (Patient's Date of Birth)

for: ____

(Dates, Illness, All Records, ETC.)

Be released to: Mt. Sterling Pediatrics- Dr. Brandy Fouch/ Shasta Kessler ARNP

(Physician's Name)

I hereby authorize you to release my child's medical records to Mt. Sterling Pediatrics. This information 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. My written revocation must be submitted to the Privacy Officer at Mt. Sterling Pediatrics. I understand this request is valid from the date of my signature.

SIGNATURE: ______________________________________

RELATIONSHIP: ______________________________________

DATE: ______________________________________

www.mtsterlingpediatrics.com

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