Bluegrass Pediatrics & Internal Medicine, PLLC
104 Canewood Center Drive, Suite #2
Georgetown, KY 40324
(502) 863-2818

Authorization to Disclose Medical Information

Patient Name: ____

Social Security Number: ______________________ Date of Birth: ________________________

I am signing this authorization so my Health Care Providers can disclose my health care information to the persons listed below, and openly discuss that information with them.

I, ____________________________________, hereby authorize my physicians, their staff, any associated hospitals, nurses or other healthcare providers working directly with Bluegrass Pediatrics & Internal Medicine, PLLC to fully disclose my Individual Identifiable Health Information to any or all of the following authorized persons (my "Personal Representatives"):

(1) Name: ____

Relationship to patient: __________________ Telephone Number: ___________________

□ Authorization to Pick Up Prescriptions
□ Disclosure of individual's health information

(2) Name: ____

Relationship to patient: __________________ Telephone Number: ___________________

□ Authorization to Pick Up Prescriptions
□ Disclosure of individual's health information

(3) Name: ____

Relationship to patient: __________________ Telephone Number: ___________________

□ Authorization to Pick Up Prescriptions
□ Disclosure of individual's health information

My Health Care Providers are expressly authorized to answer questions posed by the Personal Representatives listed above and openly discuss with them my condition, treatment, test results, prognosis, and all other information pertinent to my health care, even if I am fully competent to ask questions and discuss my medical condition. This document constitutes a full authorization to disclose any Individual Identifiable Health Information to the Personal Representatives named in this authorization.

I recognize and intend that this may result in multiple persons having the authority to obtain my protected Individual Identifiable Health Information.

______________________________ Signature of Patient or Personal Representative	______________________________ Date
______________________________ Name of Patient or Personal Representative	______________________________ Description of Personal Representative's Authority