

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

**Authorization to Release Patient Identifiable Health Information**

Patient Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Bluegrass Pediatrics & Internal Medicine, PLLC to receive or disclose my protected health information described below to/from \_\_\_\_\_ located at \_\_\_\_\_.

The purpose for requesting this release of information is (check one):

- At the request of the individual
- Other (please describe) \_\_\_\_\_

The authorization for use and/or disclosure applies to the information described below [Mark those that apply]:

- Any and all records in the possession of Bluegrass Pediatrics & Internal Medicine, PLLC including mental health, HIV, and /or substance abuse records. [Cross out any item you do not authorize to be released]
- Records regarding treatment for the following condition or injury on \_\_\_\_\_ or \_\_\_\_\_ or about \_\_\_\_\_ or treatment provided by Dr. \_\_\_\_\_.
- Records covering the period of time \_\_\_\_\_ to \_\_\_\_\_.
- Other [please specify – include dates] \_\_\_\_\_.

This is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Bluegrass Pediatrics & Internal Medicine, PLLC. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that Bluegrass Pediatrics & Internal Medicine, PLLC may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] \_\_\_\_\_. If no date is listed, authorization will expire one (1) year from the date of signature.

I certify that I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority