

**COMMONWEALTH PEDIATRICS, PSC**

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**Patient Authorization for Use/Release of Health Care Information**

The purpose of this form is to obtain authorization for use or release of confidential health care information. Per Kentucky House Bill 250, patients have the right to receive one free copy of their medical records. There will be a charge per page for any additional requests.

I, \_\_\_\_\_, request that Commonwealth Pediatrics  
Parent or Legal Guardian  
release health care information for the following patient(s):

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to Name: \_\_\_\_\_  
Name of Individual or entity to receive this information

Address: \_\_\_\_\_  
\_\_\_\_\_

**The purpose of this request is:**

Transfer of Medical Care \_\_\_\_\_  
Moving/Relocating \_\_\_\_\_  
Personal/Other \_\_\_\_\_  
\_\_\_\_\_

**Information needed for this purpose:**

All health care information (Including previous records)\_\_\_\_\_  
Immunization Dates & Growth Charts \_\_\_\_\_  
Healthcare information relating to the following treatment,  
condition, or date of treatment: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

**\*\*THIS AUTHORIZATION EXPIRES 30 DAYS FROM DATE OF SIGNED REQUEST\*\***