

COMMONWEALTH PEDIATRICS, PSC

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**Patient Authorization for Use/Release of Health Care Information
(Records Coming In to Commonwealth Pediatrics)**

(The purpose of this form is to obtain authorization for use or release of confidential health care information.)

I, _____, authorize _____
Parent or Legal Guardian Name of individual or entity

to release medical records on the following patients:

Patient Name: _____ Date of Birth: _____

to **Commonwealth Pediatrics, PSC**
1780 Nicholasville Road, Suite 301
Lexington, KY 40503

for the purpose of: Transfer of all records _____
Moving/Relocating _____
Immunization Records _____
Other health care information (please specify): _____

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