ONE pediatrics℠

**RELEASE OF INFORMATION**

133 Buck Creek Rd
Simpsonville KY 40067

(502)405-2020 Fax: (502) 405-2079

I hereby authorize One Pediatrics at Simpsonville to release my child/children's protected health information to:

Name of Physician/Entity: _____ Phone #: _____

Address: _____

Parent/Guardian Name(s): _____

| Name of Child/Children: | Date of Birth: | Year Last Seen: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

These Records will be disclosed for the following reason(s):

- ☐ Insurance change (New insurance is _____ )
- ☐ Moving or need to be closer to home
- ☐ Child nearing 18 (if ALREADY 18 OR OLDER, MUST SIGN OWN RELEASE)
- ☐ Legal Purposes
- ☐ Other

The Minimum records necessary include:

- ☐ Immunizations with dates
- ☐ treatment/correspondence from _____ to _____ (dates).
- ☐ ENTIRE MEDICAL RECORD

I understand that I can revoke this authorization, in writing, at any time by sending written notification to the above named practice. 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 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 child/children's protected health information.

| Print name of Parent or Legal Guardian: | Date: | Phone Number: |
|---|---|---|
| _____ | _____ | _____ |

| Signature: | Relationship: |
|---|---|
| _____ | _____ |