Internal Medicine & Pediatric Associates

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Medical Records Request

Please print clearly and complete the following information.

Patient Name: ________________________________ **Today's Date:** __________________

Date of Birth: _________________________________ **Phone Number:** ________________

My Personal Health Information to be released (patient to designate below)

- ❑ Lab Tests and Blood Work
- ❑ Imaging and Other Test Results
- ❑ Medication and Prescription Information
- ❑ Entire Medical Record
- ❑ Progress Notes

Requesting Personal Health Information FROM:

Name of Facility/Provider ____

Street Address ____

City, State, and Zip Code ____

Phone _______________________________ Fax _________________________________

I authorize you to release my personal health information as designated above. When my information or medical records are used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Internal Medicine & Pediatric Associates has acted upon their reliance of my authorization. I understand this request is valid for one year from the date of signature if additional documents are needed in the future, unless I revoke my request in writing. My written revocation must be submitted to the Privacy Officer at Internal Medicine & Pediatric Associates at the above address.

_____________________________________ _______________________

Patient Signature Signature Date

Fax Medical Records (30 pages or less) to 502-241-5083.

Mail Medical Records over 30 pages to:
Internal Medicine & Pediatric Associates
7101 W. Highway 22
Crestwood, KY 40014
Phone: 502-241-6567