Growing Healthy Children
Growing Children Happy and Healthy

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the release of my medical records:

TO/FROM: (circle one)

Growing Healthy Children
9905 Shelbyville Road
Louisville, KY 40223
Office: 502-425-5166 Fax: 502-327-0526

TO/FROM: (circle one)

Mail or Picking up Records (circle one)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient(s) Name and Date of Birth

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Please check that apply:

__ Transferring Out __ Insurance __ Personal Interest

__ Continued Medical Care (Specialist) __ Legal Claim

Specific Request: _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

_____ _____

Print Name of Patient (18 or over) or Legal Representative Date

_____ _____

Signature of Patient (18 or over) or Legal Representative Phone

_____

Relation to Patient

James M. Hinkebein, M.D., Bruce A. Davis, M.D., Thomas E. McCormick, M.D., Lorraine A. Rust, M.D., Nicholas M. Hinkebein, M.D., Liz Dedman, M.D.

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