Mack and Poole Pediatrics, PLC

2351 Huguenard Drive, Suite 200
Lexington, KY 40503
Phone: 859-260-7700
Fax: 859-260-7797

Patient Authorization for Use/Release of Health Care Information

(Records Coming In to Mack and Poole Pediatrics)

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

Please DO NOT fax records.

I, ______________________________, authorize: __________________________________
Parent or Legal Guardian — Name of individual or entity

Address: __________________________________

City, State, Zip: __________________________________

Phone and Fax: __________________________________

to release medical records on the following patients:

Patient Name: ____________________ Date of Birth: ________________________

____________________ ________________________

____________________ ________________________

____________________ ________________________

to **Mack and Poole Pediatrics, PLC**
2351 Huguenard Drive, Suite 200
Lexington, KY 40503

for the purpose of: Transfer of all records _____
Moving/Relocating _____
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****