mt. sterling pediatrics

morehead pediatrics

Medical Records Release Authorization

To: _____
(Practice name/Phone number)

I hereby request the medical records on

_____ _____
Patients name Patient's Date of Birth

For: _____
(All Records, Dates of Illness, ETC.)

Be released to: Mt Sterling/Morehead Pediatrics

I hereby authorize you to release my child's medical records to Mt Sterling/Morehead Pediatrics. This information may be subject to redisclosure 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. My written revocation must be submitted to the Privacy Officer at Mt Sterling/Morehead Pediatrics. I understand this request is valid from the date of my signature.

Signature: _____

Relationship to Patient: _____

Date: _____

Send Records to:

☐ Mt. Sterling Pediatrics
401 Commerce Circle
Mt Sterling, KY 40353
Fax: 859-498-5396
Ph: 859-498-5243

☐ Morehead Pediatrics
130 New Towne Square
Morehead, KY 40351
Fax: 606-780-9096
Ph: 606-740-0986