Ashland Children's Clinic, P.S.C.

Patient Authorization for Transfer of Protected Health Information

Patient's Name: ______________________________________

Patient's Date of Birth: ____________________

Please state the reason for transferring records: __________________________________

Protected Health Information to be released to: __________________________________

Address: ____

____

Telephone Number: _____________________ **Fax Number:** _____________________

List the protected health information to be released: __________________________________

Facility releasing protected health information:

Ashland Children's Clinic
PO Box 2378
Ashland, Kentucky 41105
(606) 329-0204 Fax: (606) 324-7770

This authorization will expire on ____________________.

When my information is 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 Ashland Children's Clinic, P.S.C. has acted in reliance upon this authorization. My written revocation must be submitted to Ashland Children's Clinic, P.S.C. PO Box 2348, Ashland, Ky 41105.

Signed by: ______________________________ ______________________________

Signature of Patient or Legal Guardian — Relationship to Patient

Date of Signature: ____________________