Willow Tree Pediatrics of Lexington

AUTHORIZATION TO RELEASE HEALTH CARE

I hereby authorize_____or its agent(s) to disclose my health Information as described in this authorization:

Patient Name:_____ Date of Birth:_____

SSN:_____

Please release health care information to:

Willow Tree Pediatrics of Lexington
2036 Regency Road Suite 2
Lexington, KY 40503

We do not accept records to be faxed or emailed. Please mail them to the address above.

Release the following information:

- ☐ Patient's Entire Medical Record
- ☐ Consultation Note
- ☐ Progress Notes for the last _____ visits/months
- ☐ Discharge Summary
- ☐ Lab Results
- ☐ Imaging Results
- ☐ Procedure/Operative Reports
- ☐ Other:_____

Expiration of Authorization: This authorization will expire (choose and complete one):

- ☐ In 90 days ; or
- ☐ When the following occurs:_____

By signing this authorization, I request my child's records to be released to the practice listed.

_____ _____

Signature of Parent/Guardian Today's Date