



**OLDHAM COUNTY PEDIATRICS, PLLC**

Joshua Honaker, MD Diane Wetherton, MD Ashli Collins, MD Greg Robson, MD

Julie Schuster, MD Amy Bindner, MD Cara Price, MD

P.O Box 247 LaGrange, KY 40031

Phone (502) 225-6277 Fax (502) 225-6278



**REQUEST FOR MEDICAL RECORDS**

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Patient's Full Name: \_\_\_\_\_  
(last) (first) (MI)

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Requesting medical records from: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize you to release my medical records to Oldham County 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 Oldham County Pediatrics. I understand this request is valid for one year from the date of my signature.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_