Ashland Children's Clinic, P.S.C.
Patient Authorization for Release of Protected Health Information

Patient's Name: _____

Patient's Date of Birth: _____

Information to be released to:	**Ashland Children's Clinic** **J. Roger Potter, MD** **Ann W. Craig, MD FAAP** **Ishmael W. Stevens, Jr., MD FAAP**
Address:	**P.O. Box 2348** **Ashland, Kentucky 41105**
Telephone Number:	**(606) 329-0204**
Fax Number:	**(606) 324-7770**

Information to be released:
Complete chart including office notes, growth and development charts, immunizations, problem list, correspondence, labs and imaging reports.

Name of provider releasing information: _____

Address of provider: _____

Phone Number: _____ **Fax:** _____

Reason for disclosure: _____

This authorization will expire on: _____

When my information is used or disclosed pursuant to this authorization, it 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 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. P.O. Box 2348, Ashland, Ky 41105.

Signed By: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

Date of Signature: _____