AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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Patient:_____ Date of Birth:_____ Date:_____

Address:_____
Street Address City State Zip Code Telephone

X_____ _____ _____
Signature of Patient or Patient's Representative Relationship to Patient Expiration Date or 30 days

X_____, Signature of Witness

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED

I hereby authorize the use and disclosure (release) of my medical record information:

From: **Bright Future Pediatrics, P.S.C.**
4885 Houston Rd. Suite 101, Florence, KY 41042
Phone: 859-371-7400 / Fax: 859-371-8472
Email: frontdesk@bfpeds.com

To:_____
_____
_____

The information to be released includes: _____Entire medical record _____ Other_____

The Medical Record Information will be used and/or disclosed for the following purposes:
_____ At the request of the individual _____Changing primary care physicians _____Changing/seeing specialist
Other:_____

I acknowledge and agree that the term Medical Record Information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please exclude the following information if it is part of my Medical Record Information
(Check any or all you want excluded from this authorization for use or disclosure.)

_____Chemical dependence/substance abuse _____Psychiatric/psychological conditions _____Sexually transmitted disease
_____ Alcohol _____Drugs

I understand this authorization shall remain in effect for a period of 30 days. I further understand I may revoke this authorization at any time by notifying Bright Future Pediatrics, P.S.C. in writing. However, if I choose to do so, I understand my revocation will not affect any actions taken by Bright Future Pediatrics, P.S.C. before receiving my revocation.

I understand I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request to Bright Future Pediatrics, P.S.C. Privacy Officer. I also understand I have the option to "opt-out" of receiving communication from my provider should I choose to do so as long as I provide them with the request in writing.

I am designating _____, who is at least 18 years of age and who may be required to show photo I.D. to pick up my medical records.

Patient received **one, free** copy by:_____ Date:_____

Refusal to sign this authorization in no way affects my treatment, payment or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. Updated 03/19/2025