Pediatric Partners of Jeffersontown, PLLC

Joseph Pappalardo, MD, Mari Knights, MD, Debbie Wallace, MD, Sally Diebold, MD
3840 Ruckriegel Parkway, Suite 105 Phone (502) 261-7227
Louisville, Kentucky 40299 Fax (844) 965-9615

Authorization for Release of Protected Health Information

I,____________________________, hereby authorize Pediatric Partners of Jeffersontown, PLLC to request the following health information on the following children:

____ DOB: __________________________________
____ DOB: __________________________________
____ DOB: __________________________________

Previous Physician Name: ____
Address: ____
Phone Number: ____________________________ Fax Number:_______________________________________

Please send records one of the following ways:

- Fax to **844-965-9615 (Preferred)**
- Mail to **3840 Ruckriegel Parkway, Ste. 105, Louisville, KY 40299**

Please indicate reason for records to be released below:

- ☐ Moved / Change in address
- ☐ Hours inconvenient
- ☐ Waiting time too long
- ☐ Dissatisfaction with doctor
- ☐ Dissatisfaction with treatment
- ☐ Dissatisfaction with staff
- ☐ Other ________________

- **This Authorization for use and/or disclosure applies to the information described below: (Mark all that apply)**
  - ☐ Any and all records, including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)
  - ☐ Records regarding treatment for the following condition or injury________________, on or about________________________________.
  - ☐ Records covering the time period of__________________to______________________.
  - ☐ Other (Please specify and include dates) ____.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taking in reliance on this authorization or according to law. Written revocation must be sent to the person I authorize to release the information.
- This authorization will expire one (1) year from the effective date as provided below unless otherwise specified.
- I understand I have the right to: Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights). Refuse to sign this authorization. Receive a signed copy of this authorization.

____ ______________________________________
Signature of Patient or Personal Representative Date