Internal Medicine & Pediatric Associates
Phone: (502) 241-6567
Fax: (502) 241-5083

Tony G. Karem M.D Ilana C. Kayrouz, M.D. Michael J. Kelley M.D Tracy L. Ragland M.D

Medical Records: Request

Patient Information: Please Print

Name: ____

Date of Birth: _______________________

SS#: _____________________________

Requesting Information form:

Name of Facility/Provider: ______________________________

Address: ____

City/State/Zip:_______________________________________

Please fax or Mail records to: Internal Medicine & Pediatric Associates
P.O Box 548
Crestwood, KY 40014
Fax: 502-241-5083 Phone: 502-241-6567

Information to be released:

_________ Entire Medical

________ Record Progress Notes

_________ X-Ray Reports

________ Laboratory Reports

I hereby authorize you to release my medical records including diagnosis and treatments. 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 IMP A has acted in the reliance upon this authorization. My written revocation must by submitted to IMPA to the attention of the Privacy Officer at the above address.

I understand this request is valid for one year from the date of signature if future documents are needed, unless I otherwise revoke my request in writing.

Signature of Parent or Legal Guardian : _______________________________

Date: _____________________________