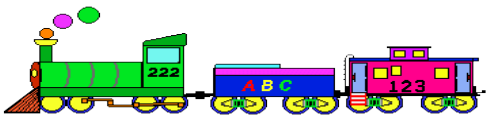

Pediatrics

Dr. Jeremy L. Warner Dr. John M. Jansen

3320 Tates Creek Road, Suite 302
Lexington, KY 40502
P: 859-269-4604 F: 859-266-0062

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print)

Name: _____

Birthday: _____

Current Phone # (in case of questions): _____

Records From:

_____
MD or Group Name

_____
Mailing Address

_____
City, State, Zip Code

Records To:

_____
MD or Group Name

_____
Mailing Address

_____
City, State, Zip Code

Information Requested:

_____All Records
_____All Dates

_____Other
_____Specific Dates

I hereby request and authorize the release of requested health care information from the above name party to the corresponding above named part. This authorization will expire one year from the date signed. I have the right to revoke this authorization in writing at my discretion. My written revocation must be submitted to the Privacy Officer at Drs. Warner and Jansen.

_____ _____
Patient or Guardian and Relationship Date

Are you transferring to another practice? _____

**Our office is unable to release records from other practices. If you need a copy of records from your previous pediatrician's office, we suggest that you have the records sent to you and have a copy made for yourself. ** This is due to the National HIPAA Law. Thank you for understanding