# *Town Family Doctor, PLLC*

## Vedad Seremet MD

## Authorization to request medical records

An individual may request their personal medical records or the medical records of a person they legally represent.
A person requesting the medical records of a minor child must have legal custody. If applicable, legal documentation is required.

**I Request a Copy of the Following Patient's Medical Record:**

Full Name (Patient) _____ Date of Birth: _____
Social Security Number (Patient): _____ Contact Phone #: (_____) _____

**Information Requested:**

_____

**Information Requested From:**

Provider/Facility: _____
Address: _____ City/State/Zip: _____
Phone Number: (_____) _____ Fax Number: (_____) _____

**Information Requested For the Following Reason:**

Continued Medical Care Other: _____

Please Send Records To:

**Town Family Doctor, PLLC**
**Attn: Record keeping dept.**

**9501 Norton Commons Boulevard**
**Unit B**
**Prospect, KY 40059-7522**

**Phone: (502) 618-2472**
**Fax: (502) 618-2479**

I understand this authorization is good for ninety (90) days unless otherwise specified _____. I am aware that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, this information may be re-disclosed and is no longer protected by these regulations. Furthermore, per 94 HG250, I am entitled to one (1) free copy of my medical records. Additional requests will be charged at $1.00 per page. Patient's obtaining their medical record for personal use must present in person with picture identification. Our policy regarding release of private health information is available to you upon request.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND CONSENT TO RELEASE OF THE AFORE MENTIONED MEDICAL RECORDS.

_____ _____ _____
**Patient Signature** **Parent/ legal guardian signature** **Date**