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AUTHORIZATION FOR THE RELEASE OF INFORMATION

Date_____

Patient Name_____ Social Security Number_____

Address_____

Date of Birth_____ Phone_____

I authorize the release of medical and billing information (as indicated below):

From:_____ To:_____

_____ _____

_____ _____

I would like_____

from the following dates:_____through_____.

Please indicate the purpose for release:_____

This authorization will expire in 60 days unless indicated. Extension of expiration date for _____days.

Please discuss/release a copy of all of my medical records, including, but not limited to, progress notes, operative notes, laboratory results, and diagnostic results. Or please release just the following:_____

By my signature I authorized release of medical records.

Patient/Legal Representative Signature_____Date_____

Relationship of representative to patient_____ Reason for representative:

Minor_____ Incompetent_____ Deceased_____

Signature of staff witness_____

You have the right to obtain a copy of you medical records. The law requires a signed authorization form which contains certain criteria included on this form. This form must be fully completed before any medical information can be released. Incomplete forms may be returned for completion. Kentucky law allows for one free copy of your medical record. This free copy is one requested by you for yourself or for a third party. Additional requests will cost $1.00 per page plus mailing costs. It is advised you keep a personal copy of any medical information you request to avoid future costs of obtaining copies. This request will be completed within 30 days of receipt. You will be notified via fax or phone if the records cannot be processed in 30 days. If you would like to pick up your records, indicate this on the form with a phone number where you can be contacted. Otherwise, records will be mailed to the address listed on the authorization.