KENTUCKY HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

Please fill out all sections or the form may be returned to you.

Patient Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Send Information from:

Send to: _____

I would like records from the following dates: _____ through _____

(This can be a very specific date or more general. Examples: July 15, 2007 or June 2006 - Feb 2007)

Please check the records you would like:

☐ Records related to (specify): _____ (examples: car accident or appendectomy)

☐ Discharge Summary	☐ Pathology Report(s)	☐ X-Ray Report(s)
☐ TB Screening	☐ Laboratory Report(s)	☐ X-Ray Image(s)
☐ Immunization Record	☐ Photo/Video/Other	☐ **All Known Medical Records**
☐ ER Notes	☐ Outpatient Notes	☐ Other: (specify) _____
☐ Surgery Reports	☐ Psychological Test Report	

Sharing of Special Protected Records: I authorize the sharing of information about:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS)	☐ YES	☐ NO / NA
b. The diagnosis or treatment of drug and/or alcohol abuse	☐ YES	☐ NO / NA
c. The treatment and/or consultation for mental health or psychiatric disorders	☐ YES	☐ NO / NA

Reason records are needed (check all that apply):

☐ For another doctor or hospital ☐ Social Security/disability ☐ Legal ☐ Personal use ☐ Other (specify) _____

This Authorization will expire on _____ (date).

If no date is included the Authorization will expire in 90 days.

- I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective except to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
- I further understand that treatment payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

_____ _____

Date **Signature of Patient**

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:

☐ Minor ☐ Incompetent ☐ Deceased

Proof of designation must be filed in the chart or sent with this request.

_____

Signature of Legal Representative and Relationship to Patient

_____

Signature of Witness for Psychiatric Records