AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME ____ DATE OF BIRTH______________________

SOCIAL SECURITY # ________________________ DATES OF PROFESSIONAL SERVICES ____________________________________

1. I HEREBY REQUEST AND/OR AUTHORIZE ____

2. TO DISCLOSE THE HEALTH INFORMATION, AS DESCRIBED BELOW, OF THE ABOVE-NAMED PATIENT TO: **COMMUNITY FAMILY CLINIC, PLLC**

□ 784 HWY 36 FRENCHBURG, KENTUCKY 40322 PHONE: (606) 768-9190 FAX: (606) 768-6249

□ 125 FOXGLOVE DRIVE, SUITE D MT. STERLING, KENTUCKY 40353 PHONE: (859) 498-3333 FAX: (859) 498-3332

□ 17 MILLER DRIVE OWINGSVILLE, KENTUCKY 40360 PHONE: (606) 674-3033 FAX: (606) 674- 3036

OR TO THE FOLLOWING PERSON/ORGANIZATION: ____

____

3. INFORMATION TO BE RELEASED – CHECK YES OR NO <u>AND</u> INITIAL (MAY INCLUDE SUBSTANCE USE DISORDER RECORDS, IF APPLICABLE)

YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS	YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS
		MAJOR EVALUATIONS				ORDER & PROGRESS NOTES	
		TREATMENT PLANS				DISCHARGE SUMMARIES	
		APPOINTMENT HISTORY				LABORATORY RESULTS	
		OFFICE NOTES				RADIOLOGY RESULTS	
		HISTORY & PHYSICAL				PATHOLOGY REPORTS	
		CONSULTATION NOTES				EMERGENCY ROOM RECORD	
		ADDICTION TREATMENT				OPERATIVE REPORTS	
		URINE DRUG SCREENS				NURSE NOTES	
		MEDICATIONS				OTHER:	

4. PURPOSE OF RELEASE: □ Personal Interest □ Legal Claim Processing □ Social Security or Disability Claim
□ Continuity of Care □ Insurance Claim Processing □ Other ___________________________________

5. TIME LIMITATION OF RELEASE: THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:
   a. I understand that this authorization will expire □ one (1) year from date of signature □ on the following date ______ / ______ / ________ □ or upon disclosure of the records to the above-named Person/Organization.
   b. I understand that I may revoke this authorization at any time, providing the information has not already been disclosed. I also understand the Notice of Privacy Practices explains how I may revoke my authorization.
   c. I understand that any disclosure of this health information is voluntary, and I may refuse to sign this authorization and that I do not need to sign this form in order to ensure treatment.
   d. I understand that any disclosure of information carries with it the potential for the unauthorized redisclosure by the recipient and no longer protected by federal confidentiality rules.

Prohibition on redisclosure: I understand that this information has been disclosed from records protected by Federal confidentiality rules **(42 CFR Part 2 and 45 CFR Parts 160 and 164**) and/or KY state law. The Federal rules and/or KY state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or KY state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients. The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or records from other healthcare providers. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **INITIALS** _____________

6. I UNDERSTAND THERE MAY BE A CHARGE FOR THIS REQUEST AND I WILL BE NOTIFIED OF THE COST BEFORE ANY CHARGES ARE INCURRED.

7. RECORDS OF ROUTINELY MAILED. PERSONAL ID IS REQUIRED WHEN RECORDS ARE PICKED UP
   1 PHOTO ID OR 2 OTHER FORMS OF ID: □ SOCIAL SECURITY CARD □ DRIVER'S LICENSE □ SCHOOL/WORK ID □ OTHER ______________________

Date: ______________________________________ Patient Signature____

Witness: __________________________________

If signed by Representative*:* Printed Name: ________________________________

Signature of Legal Representative: ____

Relationship: ____

Address: ____

City: ________________________________ State: __________ Zip: ____________

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The authorization must be signed by the patient if 18 years of age or over, or by a minor (under 18) if emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent of legal guardian for any other minor or by patient's representative (i.e. Power of attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court is needed as proof for executor or administrator and a written document is needed as proof of power-of-attorney. MR-15 Effective 04/14/2003