Bluegrass Internal Medicine
3346 Professional Park Drive
Owensboro, KY 42303
Phone: 270-685-1066 • Fax: 270-685-0881

AUTHORIZATION FOR RELEASE OF INFORMATION (MEDICAL RECORDS)

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:________________________ Date of Birth:______________ SS#:____________________

Persons/Organization releasing the information:____

Persons/Organization receiving the information:____

~Check type of information authorized to be used and/or disclosed~

Complete Chart	_____	History & Physical exam	_____
Pathology Reports	_____	Discharge Summary	_____
Progress Notes	_____	Consultative Reports	_____
Lab Reports	_____	Operative Reports	_____
X-ray Reports	_____	Hospital Records	_____

Date range of information to be released: From _____________________ to ________________________

For the following purpose(s): ____
____

This authorization shall remain in effect until _________ (date) or _________ (occurrence or specific event) at which time this authorization to disclose the identified health information expires. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

•I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any action the organization took before they received the revocation.

•I understand that my medical records (including any psychiatric, alcohol, drug abuse information) are protected by Federal Regulations and cannot be disclosed without written consent unless otherwise provided for in said regulations.

•I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.

_______________________________________   __________________________
Signature of patient or patient's representative   Date

Print name of patient's personal representative ________________________ Relationship to patient: ____________

_______________________________________   __________________________
Signature of Witness   Date