

Authorization to Release Patient Identifiable Health Information

Patient Name: _____ Social Security Number: _____

Patient Address: _____ Phone: _____

City, State, Zip Code: _____ Date of Birth: _____

I hereby authorize _____ to disclose my protected health information described below to: _____

The purpose for requesting this release of information is (check one):

- at the request of the individual
 other (please describe) _____

This authorization for use and/or disclosure applies to the information described below:

- Records regarding treatment for the following condition or injury: _____
 Records regarding my treatment with the following physician(s): _____
 Records covering the period of time _____ to _____
 Other (please specify - include dates) _____
 Any and all records in the possession of the Lexington Clinic including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)

This is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Director of Medical Records, Lexington Clinic, 1221 South Broadway, Lexington, KY 40504. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that the Lexington Clinic may not condition my treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires one (1) year from the date of signature unless a specific date or event is listed: _____

I certify that I have received a copy of this authorization. I understand that this request must be filled out entirely to ensure timely release of my information.

Signature of Patient or Personal Representative_____
Date_____
Name of Patient or Personal Representative_____
Witness_____
Description of Personal Representative's Authority