

Authorization for the Release of Medical Records Lexington Clinic

1) TELL US ABOUT THE PATIENT

Name:	DOB:	SSN: XXX-XX-	MRN:
Address:			
City:	State:	Zip:	
Phone:	Email:		

2) WHERE AND HOW ARE WE SENDING THE RECORDS? (PLEASE COMPLETE DELIVERY OPTION A, B OR C)

Send To:	Phone # of Requestor:	
a. Mail to Address:		
City:	State:	Zip:
b. Email (Via secure portal through Medi-Copy Inc.):		
c. Fax to (Healthcare Providers Only):	PLEASE CHOOSE ONLY ONE OPTION (A, B OR C)	

3) WHAT INFORMATION WOULD YOU LIKE RELEASED?

- Provider(s) _____ All Clinic Providers
- Include Associate Practices (List Here) _____
- Records covering period of time: _____ to _____ All dates of treatment
- Records regarding treatment for the following condition(s) or injury(ies): _____
- Ambulatory Surgery Center Records (Check here if requesting Operative Report only)
- Labs/Path Only Radiology Reports Only Office Notes Only Immunization Records Other _____
- Records including mental health, HIV, and/or substance abuse records (cross out any item you do not authorize disclosure.)

4) PURPOSE OF DISCLOSURE

- Personal Use
 Transfer/Continuity of Care
 Litigation/Legal
 Other

5) FEE SCHEDULE (IF APPLICABLE, MEDI-COPY WILL INVOICE YOU. PLEASE DO **NOT** SEND PAYMENT TO LEXINGTON CLINIC.)

- Per KRS 422.317, patients are entitled to the first copy of their medical record free of charge. Each additional copy shall be \$1.00 per page.
- Postage \$6.00 / Records on CD \$10.00 (**Please do not send payment to Lexington Clinic. You will be invoiced by our vendor.**)
- Records transferred directly to another healthcare entity are free of charge.

I hereby agree to fees listed above and understand fees are non-refundable once services are rendered. Payment is due on receipt of invoice and payments received after 30 days are subject to \$5.00 late fee. ***There is no additional charge for records emailed, faxed or picked up at facility.**

6) PATIENT'S SIGNATURE

I understand this is the minimum amount of information necessary for the purpose described above. No other information will be disclosed. I understand I have the right to revoke this authorization, in writing, at any time, by sending such notification to the Director of Health Information at the address noted on this form. I understand 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 Lexington Clinic may not condition my treatment or payment on whether I choose to sign this authorization. I understand information used/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. I understand this authorization expires in 1 year from date of signature unless a specific date/event is listed _____. I understand I will receive a copy of this authorization. I understand this authorization must be filled out in its entirety to ensure timely release of my information.

Signature of Patient or Authorized Person:	Date:
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Authorized Person's Relationship:	Reason Patient Unable to Sign (if applicable):
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Lexington Clinic Employees: This authorization does not permit usage of our computer systems to access your / a family member's.