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.
- Records on CD $6.50 **(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:
Authorized Person's Relationship:	Reason Patient Unable to Sign (if applicable):

LC Employees: This authorization does not permit usage of our computer systems to access your / a family member's PHI.