Lexington Clinic Health Information 1221 South Broadway, Lexington KY 40504 • (859) 258-4837 • FAX (859) 258-4489

Lexington Clinic and Lexington Clinic Associate Practices Associate Practices (Fill in all that apply.) Patient's full name:	Associate Practices				
(Fill in all that apply.) Patient's full name: MRN Date of Birth: /					
Date of Birth: //					
Purpose of release: Request of individual Transfer of care Other I authorize	Patient's full name:			_ MRN	
Mail Record Recipient's Address: City: State: ZIP: *FAX: () Information to be Released: (Please check all that apply) Provider(s): All Lexington Clinic providers Include Provider(s) from Associate Practice(s) at top of this form.) Records covering period of time: to					
Recipient's Address:	I authorize to	release my health in	formation to:	_	
City:			I will pick up		
Provider(s): All Lexington Clinic providers Include Provider(s) from Associate Practices. (Fill in Associate Practice(s) at top of this form.) Records covering period of time: to All dates of treatment Records regarding treatment for the following condition(s) or injury(ies): All dates of treatment Ambulatory Surgery Center Records - (Check here if requesting Operative Report only]) Other Any and all medical records in the possession of Lexington Clinic including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.) 1. I understand this is the minimum amount of information necessary for the purpose described above. No other information will be disclosed. 2. 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 Health Information at the address noted at the top of this form. I also understand that my revocation is not effective the extent that the persons I have authorization and that Lexington Clinic may not condition my treatment or payment or whether I sign this authorization. 3. I understand that I do not have to sign this authorization and that Lexington Clinic may not condition my treatment or payment or whether I sign this authorization expires one (1) year from the date of signature unless a specific date or event is listed: 3. I understand that I will receive a copy of this authorization and that this request must be filled out in its entirety to ensure timely release of my information. 3. I understand that I will receive a copy of this authorization and that this request must be filled out in its entirety to ensure timely release of my information.	City:State: ZIP:	*FAX: ()			
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Signature of Patient or Authorized Person Date Contact Telephone Number	Signature of Patient or Authorized Person	Date	Contact Teleph	one Number	
Authorized Person's Relationship Reason Patient is Unable to Sign	Authorized Person's Relationship	Reason Patient is Unable to Sign			

 ALL AUTHORIZATIONS MUST BE MAILED TO ADDRESS AT TOP OF THIS FORM.

 WE CAN ACCEPT FAXED REQUESTS FROM HEALTHCARE PROVIDERS ONLY.

 Lexington Clinic Employees:

 This authorization does not permit usage of our computer systems to access your / a family member's patient information.