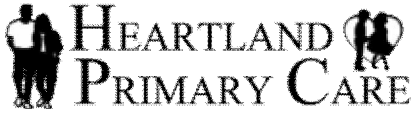

2412 Ring Road ~ Elizabethtown, KY 42701
Phone (270) 765-5926 Fax (270) 763-0051

Authorization for Use of Protected Health Information (Release of Medical Records)

INSTRUCTIONS FOR COMPLETING THIS FORM

Complete all required sections.
Sign and date form.

You may:
Drop by office

Fax
(270-763-0051)

Mail
2412 Ring Road, Suite 200
Elizabethtown, KY 42701

Authorization for Use of Protected Health Information

2412 Ring Road ~ Elizabethtown, KY 42701
Phone (270) 765-5926 Fax (270) 763-0051

Patient Name: ____

Date of Birth: ______________________ SS#: ______________________________

I authorize Heartland Primary Care to:

❑ **RELEASE** Medical Records to: ❑ **OBTAIN** Medical Records from:

Practice Name: ____

Address: ____

City: ______________________ State: ____________ Zip: ________________

Phone: ____________________ FAX: ________________________________

Purpose of Request

❑ Continue Care ❑ Insurance Claim ❑ Other:

❑ Attorney ❑ Personal Use ____________________

Information Requested

❑ Entire Medical Record

❑ Other:

____

____

Specific Date(s): ________________

_______ I specifically authorize release of information pertaining to:

- HIV/AIDS
- Alcohol/Drug Abuse Treatment
- Mental Health
- Genetic Testing

This authorization will expire 30 (thirty) days from the date of signature unless revoked or terminated by the patient or the patient's personal representative. It is understood that my records may not be released to me at the same time as requested. You may revoke or terminate this authorization by contacting the medical record department. I understand, however, that revocation will not apply to information that has already been released in response to this authorization.

I understand that if the person(s) or entity that receives this information is not a health care provider or health plan covered by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the information described above many be redisclosed and is no longer protected by those regulations. Therefore, I release Heartland Primary Care, its employees and Providers, from all liability arising from this disclosure of health information.

I understand that I am entitled to ONE FREE COPY of my medical records during my lifetime. Any additional copies sent for any reason are subject to a copy fee of $1 per page.

____

Patient Signature or Legal Representative Relationship to Patient Date

____

Witness Signature Date

Revised 10/26/2006