CONTEMPORARY OB/GYN OF WESTERN KENTUCKY, PSC (COB)
REVISED: 07/01/2013
Based on Final Privacy & Security Rules

Authorization to Release Health Information/Treatment Records

Last Name: _____ **First:** _____ **Middle:** _____
Other Names Used: _____ **Date of Birth:** _____ **SSN:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: ( ) _____ **Work Phone:** ( ) _____

I hereby request release of the protected health information in my health record from (date) _____to (date)_____ maintained or created by the provider named below to the recipient named below.

- ☐ Most recent Progress Notes
- ☐ Pathology/Lab Reports, HIV, STD
- ☐ Imaging Reports
- ☐ Discharge Summaries
- ☐ Billing Records
- ☐ Entire Health Record *****(Excludes Psychotherapy Notes)
- ☐ Reports of Operations/Surgeries/Procedures
- ☐ Other_____
- ☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an Individual's Health Information must be completed to obtain additional records.)

- ☐ I will pick up copies of my records
- ☐ Fax my records to: _____
- ☐ Mail copies of my records to the individual noted below
- ☐ Provide my records in electronic form: _____

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: ☐ Transfer of care ☐ legal, ☐ referral, ☐ other:_____

I understand:

I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. **Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.**

Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE.

*The information authorized for release may include protected health information and/or treatment records related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

I acknowledge that your health information contained in our electronic medical record system (EMR) contains information obtained from other healthcare entities and providers and may include information from multiple physicians, laboratories, hospitals, and other entities, including information not entered by this practice. This may include any data (sexuality, HIV, mental health, emails, etc.) that are entered, scanned, or automatically placed into the EMR both from this practice and from outside sources. This information is not redacted.

The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

I understand that if my records are released, my first copy is free if records are picked up at the office. If I choose to have the records mailed, faxed or otherwise transmitted, in accordance with the Kentucky Court of Appeals Eriksen vs Gruner regarding KRS 422.317(1) we will seek reimbursement for any charges incurred in mailing, faxing, scanning or other means to transmit the records to you or your agent. Additionally you will be charged $1.00 per page for the second copy of any paper records, **payable prior to the release** of these requested records. Records produced in digital form are free if requested via patient portal. (Make checks payable to Contemporary OB/GYN of WKY. These fees are in accordance with KRS 422.317. Records will be available within 30 days from receipt of the appropriately completed & signed request.

____ Initial

_____ _____ _____
Signature of Patient, Parent, or Legal Authorized Representative** **Relationship to Patient** **Date**

****May be requested to show proof of representative status**