



MEDICAL INFORMATION RELEASE AUTHORIZATION

Patient Identification	Name: _____ Date of Birth: _____ SS# _____ Other names known by: _____ _____
Who is releasing information	The Medical Center 250 Park Street Bowling Green, KY 42101
Release records to	Name: _____ Address: _____ _____ Fax #: _____
Dates of treatment	Dates: _____ _____ Type of treatment: (may include psychiatric, drug or alcohol abuse) _____ ER _____ Outpatient _____ Inpatient
Reason for release	_____ Medical Care _____ Insurance _____ Other, Please explain: _____ _____
Information you want released (Check what you want)	_____ H & P _____ DG SUMM _____ OR REPORT _____ PATH _____ X-RAY _____ ER REPORT _____ ENTIRE _____ OUTPT _____ OTHER _____ _____ LAB (May include AIDS/HIV information)

I understand that this authorization is valid only for a maximum of 90 days from the date below, and it covers only treatment prior to the date below.

This information may be released by facsimile machine if request warrants. The Medical Center is hereby released from any liability and the undersigned will hold The Medical Center harmless for complying with this authorization. A photostat copy of this authorization is acceptable and will be treated as original.

The undersigned acknowledges that the provision of free medical records by any healthcare provider who receives this release shall fulfill that healthcare provider's obligation to provide one free copy of the medical records, and that any future report request for medical records from the healthcare provider may result in a copying fee up to one dollar per page.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrom (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Revocation date _____ Patient/Legal Representative: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information comes with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

Patient/Legal Representative Signature: _____ Date: _____

Relationship to patient: _____