Med Center Health

MEDICAL INFORMATION RELEASE AUTHORIZATION

Who is releasing information

❑ **Barren River Regional Cancer Center**
103 Trista Lane
Glasgow, KY 42141

❑ **Bluegrass Outpatient Center / Just for Women**
1751 Scottsville Rd, Suite 9
Bowling Green, KY 42104

❑ **Bluegrass Outpatient Center Franklin**
1020 South Main Street
Franklin, KY 42134

❑ **Cal Turner Rehab & Specialty Care**
456 Burnley Road
Scottsville, KY 42164

❑ **Caverna Primary Care Clinic,** ***a Department of The Medical Center at Caverna***
1495 South Dixie Street
Horse Cave, Ky 42749

❑ **CHC Employee Health Services**
720 Second Avenue, Ste. 207
Bowling Green, KY 42101

❑ **Commonwealth Regional Specialty Hospital**
250 Park Street
Bowling Green, KY 42101

❑ **Community Clinic/ The Dental Clinic**
740 E 10th Ave
Bowling Green, KY 42101

❑ **ENT of Bowling Green**
340 New Towne Drive
Bowling Green, KY 42103

❑ **Fountain Run Rural Health Clinic**
47 Akersville Road
Fountain Run, KY 42133

❑ **Franklin Surgical Services**
1030 Brookhaven Road
Franklin, Ky 42134

❑ **Infectious Disease & Travel Medicine**
720 Second Ave, Ste. 307
Bowling Green, KY 42101

❑ **Medical Center Heart Institute**
350 Park Street, Suite 210
Bowling Green, KY 42101

❑ **Medical Center Hematology & Oncology**
350 Park St., Suite 206
Bowling Green, KY 42101

❑ **Med Center Health Surgical Specialists**
250 Burkesville Road
Albany, KY 42602

❑ **Med Center MRI**
254 Burkesville Road
Albany, Ky 42602

❑ **Med Center Health Neurology**
1221 Ashley Circle
Bowling Green, KY 42104

❑ **Medical Center Neuroscience Services**
825 Second Avenue, Ste. C3
Bowling Green, KY 42101

❑ **Medical Center Orthopaedics**
825 Second Ave East Suite C2
Bowling Green, KY 42101

❑ **Medical Center Primary Care**
1901 Scottsville Road
Bowling Green, KY 42104

❑ **Medical Center Primary Care Franklin**
1020 S Main Street
Franklin, Ky 42134

❑ **Medical Center Psychiatry**
a Department of The Medical Center
350 Park Street, Ste. 204
Bowling Green, KY 42101

❑ **Medical Center Surgical Weight Loss Program**
825 Second Avenue, Ste. A4
Bowling Green, KY 42101

❑ **Medical Center Urgentcare**
291 New Towne Drive
Bowling Green, KY 42103

❑ **Munfordville Primary Care Clinic,** *a Department of The Medical Center at Caverna*
1134 Main St. P.O. Box 340
Munfordville, Ky 42765

❑ **Orthopedics Plus Physical Therapy** (Bowling Green - South)
5796 Nashville Road
Bowling Green, KY 42101

❑ **Orthopedics Plus Physical Therapy** (Bowling Green - North)
6807 Louisville Road
Bowling Green, KY 42101

❑ **Orthopedics Plus Physical Therapy**
520 S Main Street
Brownsville, Ky 42210

❑ **Orthopedics Plus Physical Therapy**
70 Public Sqaure
Elkton, Ky 42220

❑ **Orthopedics Plus Physical Therapy**
725 South Main Street
Morgantown, Ky 42261

❑ **Orthopedics Plus Physical Therapy**
105 Robins Way, Suite 201
Russellville, Ky 42276

❑ **Orthopedics Plus Physical Therapy**
102 West Maple Street
Scottsville, Ky 42164

❑ **Rural Health Clinic**
466 Burnley Road
Scottsville, KY 42164

❑ **Scottsville Primary Care Clinic**
217 West Main Street
Scottsville, KY 42164

❑ **The Medical Center**
250 Park Street
Bowling Green, KY 42101

❑ **The Medical Center at Albany**
723 Burkesville Road
Albany, KY 42602

❑ **The Medical Center at Caverna**
1501 South Dixie Street
Horse Cave, Ky 42749

❑ **The Medical Center Cancer Treatment Center**
250 Park Street
Bowling Green, KY 42101

❑ **The Medical Center at Franklin**
1100 Brookhaven Road
Franklin, KY 42134

❑ **The Medical Center at Scottsville**
456 Burnley Road
Scottsville, KY 42164

❑ **Western Ky Diagnostic Imaging,** ***a department of The Medical Center***
1635 Scottsville Road
Bowling Green, KY 42104

❑ **Women's Health Specialists**
350 Park Street, Ste. 203
Bowling Green, KY 42101

❑ _____
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❑ _____
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Patient Identification	Name:_____ Date of Birth:_____SS#_____
Release records to	Name:_____ Phone: _____ Address:_____ Fax: _____
Dates of treatment	Dates:_____ Type of treatment:(may include psychiatric, drug or alcohol abuse)___ ER ___Outpatient ___ Inpatient __Provider Office
Reason for release	_____ Medical Care _____ Insurance ____ Legal Claim ____ Other, Please explain below: _____
Information you want released *(Check what you want)*	__ History & Physical __Pathology ___ OUTPT ___Discharge Summary __ OR REPORT __ ER REPORT __X-RAY __ LAB (May include AIDS/HIV information) __OTHER _____ _____

Account Number _____

MEDICAL INFORMATION RELEASE AUTHORIZATION
600195 (230) Rev. 01/18

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. Commonwealth Health Corporation and its subsidiaries are hereby released from any liability and the undersigned will hold Commonwealth Health Corporation 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 syndrome (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:_____

Please mail the completed authorization form to:

Attn: Release of Information
Health Information Management Department
The Medical Center
250 Park Street
Bowling Green, KY 42101

FOR OFFICE USE ONLY

❑ Released by: _____

❑ # of pages copied: _____

First free copy: Yes ❑ No ❑