Vineyard Primary Care
2851 New Hartford Road, Suite A
Owensboro, KY 42303
Phone: 270-240-2305 · Fax: 270-240-2252

AUTHORIZATION FOR RELEASE OF INFORMATION (MEDICAL RECORDS)

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or healthcare provider, the released information may no longer be protected by Federal Privacy Regulations.

Patient Name:_____ Date of Birth:_____ SS#:_____

Persons/Organization releasing the information: _____

Persons/Organization receiving the information: _____

Check type of information authorized to be used and/or disclosed

Complete Chart _____
Pathology Reports_____
Office Notes _____
Lab Reports _____
Radiology Report_____
Radiology CD _____

History & Physical exam_____
Discharge Summary _____
Consult Notes _____
Procedure Notes _____
Hospital Records _____

Date range of information to be released: _____

Information to be released for the following reasons: _____

_____

Medical Records shall be available within 3 business days of the date of the patient request: Paper_____ Electronic ____

This authorization shall remain in effect until _____(date) or _____(occurrence or specific event) at which time this authorization to disclose the identified health information expires. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, It will not have any affect on any action the organization took before they received the revocation.
- I understand that my medical records (including any psychiatric, alcohol, drug abuse information) are protected by Federal Regulations and cannot be disclosed without written consent unless otherwise provided for in said regulations.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Print name of patient's personal representative Relationship to patient

_____ _____
Signature of witness Date