Lexington Clinic Since 1920 **Health Information** 1221 South Broadway, Lexington KY 40504 ▪ (859) 258-4837 ▪ FAX (859) 258-4489

Authorization for Release of Protected Health Information

Lexington Clinic and Lexington Clinic Associate Practices

Associate Practices
(Fill in all that apply.)

_____

Patient's full name: _____ MRN _____

Date of Birth: _____ /_____ /_____ Social Security Number (Last 4): ___ ___ ___ ___

Purpose of release: ☐ Request of individual ☐ Transfer of care ☐ Other _____

I authorize _____ to release my health information to:

_____

Recipient's Address: _____

City:_____ State:_____ ZIP:_____ *FAX:( )_____

Method of Receiving:
- ☐ Mail Record
- ☐ I will pick up
- ☐ FAX (*providers only)

Information to be Released: (Please check all that apply)

Provider(s): _____ ☐ All Lexington Clinic providers

Include Provider(s) _____ from Associate Practices.
(Fill in Associate Practice(s) at top of this form.)

☐ Records covering period of time: _____ to _____ ☐ All dates of treatment

☐ Records regarding treatment for the following condition(s) or injury(ies): _____

☐ Ambulatory Surgery Center Records - (Check here if requesting Operative Report only ☐)

☐ Other _____

☐ Any and all medical records in the possession of Lexington Clinic including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)

1. I understand this is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.
2. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Director of Health Information at the address noted at the top of this form. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
3. I understand that I do not have to sign this authorization and that Lexington Clinic may not condition my treatment or payment on whether I sign this authorization.
4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.
5. I understand that this authorization expires one (1) year from the date of signature unless a specific date or event is listed:
   _____
6. I understand that I will receive a copy of this authorization and that this request must be filled out in its entirety to ensure timely release of my information.

_____ _____ _____
Signature of Patient or Authorized Person | Date | Contact Telephone Number

_____ _____
Authorized Person's Relationship | Reason Patient is Unable to Sign

ALL AUTHORIZATIONS MUST BE MAILED TO ADDRESS AT TOP OF THIS FORM.
WE CAN ACCEPT FAXED REQUESTS FROM HEALTHCARE PROVIDERS ONLY.

Lexington Clinic Employees: This authorization does not permit usage of our computer systems to access your / a family member's patient information.