AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Full Name of Patient: _____ DOB: _____

Address: _____

Patient or Guardian Phone Number: _____

Physician and/or Hospital Name: _____

Physician/Hospital Phone Number: _____ Fax: _____

1. I hereby authorize the use or disclosure of the above-named individual's protected health information (PHI) as described below.

2. I request that my protected health information (PHI) be:
   - ☐ Disclosed to patient or patient guardian
   - ☐ Disclosed to: _____
   - ☐ Obtained from: _____

3. Rockcastle Pediatrics & Adolescent, and/or designee is authorized to make this disclosure.

4. The type of information to be used or disclosed is as follows: *(check appropriate boxes and include other information where indicated)*
   - ☐ Complete Copy of Health Records
   - ☐ Immunization(s)
   - ☐ X-Ray Reports(s)
   - ☐ Laboratory Report(s)
   - ☐ Other: (please specify)

   _____

5. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
   Exclude specific records *(please specify)*: _____

6. Purpose for requesting records *(please circle)*:
   Legal Insurance Personal Use Continuation of Care

7. The information identified above may be used or disclosed to the following individuals or organizations:
   Rockcastle Pediatrics & Adolescents

8. I authorize records from these dates to be disclosed or received: *(please use specific dates)*
   _____ to _____ OR <u>all records (will be default choice if no dates are marked)</u>

9. My preferred disclosure format is (please circle): (paper in-office pick-up is default if not marked)
   In-office paper-picked up Fax Paper mailed to me

Continued on Back ⮌

Rockcastle Pediatrics & Adolescents
P.O. Box 1020 • 140 Newcomb Avenue
Mt. Vernon, KY 40456
Phone: (606) 256-4148 • Fax: (606) 256-7785

10. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy.

11. This authorization will expire in one (1) year unless otherwise specified.

12. I understand that once the above information is disclosed it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

13. I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to healthcare treatment.

Signature of Patient/Legal Guardian Relationship Date

Signature of Witness Date