

Request for Release

Name of Patient _____ Date of Birth _____ SS# _____

I HEREBY AUTHORIZE THE RELEASE OR REVIEW OF THE FOLLOWING INFORMATION FROM AND TO THE PARTIES NAMED HERE.

FROM _____ TO **Integrative Medicine of Kentucky**
Facility or Physician's Name
_____ **233 North 7th Street**
Address
_____ **Paducah, Kentucky 42001**
City, State, Zip Code
_____ **Phone 270.415.1752 / Fax 270.442.2694**
Phone Number

What date of service do you want released? _____

Information to be released (Patient must initial each item to be released)

_____ discharge summary _____ history & physical _____ laboratory tests
_____ xray & ekg _____ consultation notes _____ progress notes
_____ other, please be specific: _____

Reason for release of records _____

Expiration Date: This authorization is good until _____, or for 90 days from the date signed unless revoked by me in writing and submitted to the privacy officer at Integrative Medicine of Kentucky.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be redisclosed without my authorization.

I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization.

I understand that I have a right to inspect or receive a copy of this authorization. Copy requested and received:

No Yes Initial _____

I release the person/agency, disclosing this information from any liability arising from the release of information to the person/agency designated above.

NOTICE - RELEASE OF ALCOHOL AND DRUG ABUSE RECORDS: The Federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Patient

Date

Signature of Guardian/Representative

Date

Signature of Witness

Date