BAPTIST HEALTH
RELEASE OF INFORMATION

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

PLACE STICKER WITH BARCODE AT BOTTOM

Authorization to Release Protected Health Information

Patient Information: (Please Print)

Name:________________________________ Med Rec # or Last Four of Social____________________

Street Address or PO Box____

City, State, Zip____

Phone# ________________ Date of Birth________________ E-Mail____________________

I, the undersigned hereby authorize and direct:
( ) Baptist Health Corbin ( ) Baptist Health LaGrange ( ) Baptist Health Lexington ( ) Baptist Health Louisville
( ) Baptist Health Madisonville ( ) Baptist Health Paducah ( ) Baptist Health Richmond ( ) Baptist Health Floyd
( ) BHMG Office Practice name and address: ____________________________
and its entities, authorized agents and employees to disclose and deliver a copy of the protected health information described below in accordance with this authorization.

This information may be disclosed to and used by the following individual, organization or agency:

RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI, 48086-5054

The purpose of this release is: ( ) Continued Medical Care (◎) Legal Purposes ( ) Insurance Purposes ( ) Personal Interest
( )Other (Specify)____________________________

Dates to be released: From____________________ To ____________________

The information to be disclosed will include: (check all that apply)

____ Entire Medical Record
____ Basic Medical Record
____ Emergency Room Record
____ Face Sheet
____ Pathology
____ Radiology
____ History and Physical
____ Operative Report
____ Cardiac Cath Report
____ Discharge Summary
____ Lab
____ Electronic Format
____ Other (Specify):____________________________

I understand that my protected health information 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 drug and alcohol abuse.

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing any substance abuse information under the federal confidentiality requirements for alcohol and drug abuse patient records and the Public Health Service Act. Such information may not be used to criminally investigate or prosecute any alcohol or drug patient. Further, state law prohibits a recipient from making any further disclosure of test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains. A general authorization for the release of medical or other information is NOT sufficient for such purpose.

This authorization will expire upon the occurrence of the following event or condition: ____________________. If no event or condition is listed, it will expire in **60 days**. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to the Hospital's Health Information Management Department. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand that I will be given a copy of this Authorization form, after signing it.

________ By initialing here, I acknowledge this to be my one and only free copy of my medical record, duplicate pages will be charged $1.00 per page.

________ By initialing here, if email address above is provided, records will be sent via secure email, if no email is provided records will be placed on encrypted CD and mailed to address disclosed above.

____________________________________ ____________
Signature of Patient/Authorized Representative (include relationship or nature of authority) Date

[ ] Faxed to:________________ [ ] Given to:________________ [ ] Mailed to:________________

Mail completed request or fax to:

2600 Stanley Gault Parkway Suite 101 Louisville, Ky. 40223 (f) 502-253-4829

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