Phone (859) 278-5007
Fax (859) 278-6867

AUTHORIZATION TO DISCUSS/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information (Please Print)

Name: _____

Date of birth: _____

Telephone Number: _____

By completing this form I authorize Family Practice Associates of Lexington to **discuss** my protected health information and billing information **without restriction** with one or more of the representatives listed below

This form also gives permission for the patient representative to pick up medical forms, prescriptions, medication samples, etc. unless otherwise noted.

THIS FORM DOES NOT ALLOW ACCESS TO COPIES OF MEDICAL RECORDS

Please ensure that the designated individual(s) below can provide the following information about you prior to discussing personal health information and/or sending them to pick up medical forms, prescriptions, etc.

--Patient Legal Name **--Patient Date of Birth**

Patient Representative Information (Please Print)

NAME	RELATIONSHIP	PHONE NUMBER
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I understand there is no expiration date but I may add to, delete from or revoke this entire authorization, in writing, at any time by sending such notification to FPA. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal laws and regulations regarding privacy of my protected health information.

Signature of patient/representative _____ Date _____

Witness Signature _____ Date _____
(if signed by Legal Representative)