



Hamburg  
 1775 Alysheba Way Suite 201  
 Lexington, KY 40509-2381  
 Phone: (859) 278-5007  
 Fax: (859) 278-6867

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN# \_\_\_\_\_ Phone # \_\_\_\_\_

I hereby authorize (Physician, Clinic, Hospital or Other Health Care Provider) to Release Medical Records:

From (Name of party releasing records): \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

To (Name of party requesting records): \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**\*\*Please fill in complete mailing address - ALL records will be mailed\*\***

The information to be released includes:

- \_\_\_\_\_ Entire medical record
- \_\_\_\_\_ Billing Information
- \_\_\_\_\_ History & Physical
- \_\_\_\_\_ Progress Notes
- \_\_\_\_\_ Laboratory Reports
- \_\_\_\_\_ Other

DATE \_\_\_\_\_  
 DATE \_\_\_\_\_  
 DATE \_\_\_\_\_  
 DATE \_\_\_\_\_

If the record includes information related to alcohol or drug abuse, mental health diagnosis/treatment, AIDS or other communicable diseases, please check the ones that are applicable.  
 \_\_\_\_\_ Alcohol/Drug abuse  
 \_\_\_\_\_ Mental Health Diagnosis/Treatment  
 \_\_\_\_\_ AIDS/other communicable diseases

**I understand that the purpose of this release is for use in:**

- \_\_\_\_\_ Specialty Appointment
- \_\_\_\_\_ Insurance Claim Processing
- \_\_\_\_\_ Legal Claim Processing
- \_\_\_\_\_ Other

\_\_\_\_\_ **Change in Family Doctor - (see below)**

Reason: \_\_\_\_\_ Insurance \_\_\_\_\_ Closer to home \_\_\_\_\_ Dissatisfied \_\_\_\_\_ Other

I \_\_\_\_\_ am or \_\_\_\_\_ am not transferring my care to another physician/provider other than FPA.

**(If I am transferring care, I understand that FPA will no longer be my primary care office.)**

Please note that once your Private Health Information is disclosed, it may be redisclosed by the authorized recipient.

Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**The patient and/or legal guardian may revoke this authorization in writing at any time as per the Notice of Privacy Practices.** Release of present and future billing and lab info will be in effect until revoked.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining the authorization if such conditioning is prohibited by the Privacy Rule.

If checked, this will be considered the one free copy that you are entitled to according to Kentucky House Bill 250. Please retain this copy for your files and release only a photocopy. In the future, there will be a charge of one dollar per page plus handling charges for additional copies.

DO NOT WRITE BELOW THIS LINE

**FPA EMPLOYEE SIGNATURE**

COMMENTS \_\_\_\_\_

\_\_\_\_\_ Released to pt in office/Initials/Date \_\_\_\_\_