

Richmond Family Medicine Associates



Comprehensive Care for Your Entire Family

312 Jason Drive, Suite 9
Richmond, KY 40475
Phone (859) 575-4075
Fax (859) 575-4126
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DR. KASEY EIDSON, MD, PHD

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Last 4 Digits of SS: _____ Telephone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize Dr. Kasey Eidson of
Richmond Family Medicine Associates
312 Jason Drive, Suite 9 Richmond, KY 40475
Phone (859) 575-4075 Fax (859) 575-4126

To obtain my health information as described below **from the following:** _____

The purpose of the requested use or disclosure
____ Continuation of care ____ Personal ____ Legal ____ Insurance ____ Other (please specify)

The information to be used or disclosed includes the following specified information:

____ Discharge Summary	____ Consultation Reports	____ ED Records
____ History and Physical	____ Nursing Notes	____ Progress Notes/Orders
____ Operative Report	____ Lab Reports	____ Other (specify)
____ Pathology Report	____ Radiology Reports	_____

Dates of Treatment to be released from: _____ to _____ (please specify dates)

Sharing of Special Protected Records: I authorize the sharing of information about:

- | | | |
|--|------------------------------|----------------------------------|
| a. The diagnosis or treatment of AIDS, including the results of HIV tests | <input type="checkbox"/> YES | <input type="checkbox"/> NO / NA |
| b. The diagnosis or treatment of drug and/or alcohol abuse | <input type="checkbox"/> YES | <input type="checkbox"/> NO / NA |
| c. The treatment and /or consultation for mental health or psychiatric disorders | <input type="checkbox"/> YES | <input type="checkbox"/> NO / NA |

– I understand that I may revoke this Authorization at any time unless the Authorization was obtained as a condition of obtaining insurance coverage. My revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/ filed this authorization. The revocation shall be effective except to the extent that the Facility has already used or disclosed information and reliance on the Authorization.

– I further understand that treatment payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.

– I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers, and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Signature of Patient: _____ Date: _____

Signature of Legal Representative and Relationship to Patient: _____

Signature of Witness for Psychiatric Records: _____

For RFMA Staff Personnel Only

Faxed by: _____ Date: _____

Received by: _____ Date: _____