AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Richmond Family Medicine Associates

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
www.richmondfamilymedicineky.com

To obtain my health information as described below **from:**

_____

_____

The purpose of the requested use or disclosure is: _____ 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	☐ YES	☐ NO / NA
b.	The diagnosis or treatment of drug and/or alcohol abuse	☐ YES	☐ NO / NA
c.	The treatment and /or consultation for mental health or psychiatric disorders	☐ YES	☐ 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; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/ filed this authorization; and that 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:** _____/_____/_____