PATTIE A. CLAY REGIONAL MEDICAL CENTER
526 Eastern Bypass
Richmond, Ky. .40475
Phone (859) 623-3152
Fax (859)624-2339

Medical Record Number:___________________

AUTHORIZATION FOR RELEASE OF INFORMATION

INSTRUCTIONS: Fill in an answer to each item below. The patient or the patient's Legal Representative must sign this completed authorization before any information will be released.

I, hereby authorize Pattie A. Clay Regional Medical Center to release certain medical information as indicated below

To: ____
____
____

PATIENT IDENTIFICATION:

NAME____ DATE OF BIRTH ___________________________

ADDRESS____

Information to be released covers the period(s) of hospitalization ________________________ to __________________

and/or outpatient treatment(s) on ____

INFORMATION REQUESTED:

_____ Entire Medical **Record-Excluding HIV/AIDS results**
_____ Face Sheet
_____ Operative Report
_____ Pathology Report
_____ Laboratory Report
_____ Emergency Room Record
_____ Discharge Summary
_____ History and Physical
_____ Radiology Report
_____ Other (specify) _________________________

I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including the results of HIV tests (virus that causes AIDS) _____ Yes ____ No Pt. Initial ________
The diagnosis or treatment of drug and/or alcohol abuse _____ Yes ____ No Pt. Initial ________
Treatment and/or consultation for mental health or psychiatric disorders _____ Yes ____ No Pt. Initial ________

REASON FOR REQUEST:

_____ External Review
_____ Insurance
_____ Future Medical Care
_____ Legal Claim

PERSONAL IDENTIFICATION PRESENTED:

_____ Social Security Card
_____ School/Work I.D.
_____ Driver's License
_____ Other

I understand that I may ***REVOKE*** *this release* at any time, in writing, but the request shall remain valid until revoked, or upon sixty (60) days from the date below, whichever occurs first, ***EXCEPT*** to the extent that disclosure made in good faith has already occurred.

The facility, its employees and officers, and attending physician(s) are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

IF PATIENT IS A MINOR - Are you currently divorced or separated from the father/mother? Yes_____ No_____ If you checked yes, you must provide this office with proof of custody before records can be released.

If patient is unable to sign, secure consent of the Legal Representative and indicate reason below:

_______Minor ________Incompetent _________Deceased __________ Other - Explain____________________________

____
Signature of Patient

____
Date of Signature

____
Signature of Legal Representative and Relationship to Patient

____
Signature of Witness