PIKEVILLE MEDICAL CENTER

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization, if signed, will authorize _____ to use and disclose certain protected health information about the patient named below.

**This authorization is voluntary, and you may refuse to sign this authorization.**

1. I hereby authorize disclosure of protected health information relating to:

   Patient Name: _____ Date of Birth: _____ SSN: _____
   Address (complete including Zip Code): _____
   _____

2. The purpose of the disclosure is:
   - □ Future and/or Continuing Medical Care
   - □ Insurance Claim Processing
   - □ Legal Claim Processing
   - □ Other: (Specify) _____

3. The information to be disclosed is ***(if the request is for specific information, rather than the entire health record, you must specify the exact information to be disclosed, including dates of service. This authorization will not be honored without this required information)*:**

   □ Entire Health Record [ or the specified records as indicated below ]

| DOCUMENT/REPORT/STUDY | DATE OF SERVICE |
|---|---|
| □ History and Physical Examination | _____ |
| □ Consultation Reports | _____ |
| □ X-Ray Reports | _____ |
| □ Radiology Films | _____ |
| □ Laboratory Tests | _____ |
| □ Operative Reports | _____ |
| □ Discharge Summary | _____ |
| □ Progress Notes | _____ |
| □ Photographs, Videotapes, or Digital/Other Images | _____ |
| □ Physical, Occupational, Speech Therapy | _____ |
| □ Home Health | _____ |
| □ Other (Specify) _____ | _____ |

4. **I understand that this information may include information relating to:**
   - ***Acquired immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection***
   - ***Treatment for Drug or Alcohol abuse***
   - ***Mental or Behavioral Health or Psychiatric care***

5. The person(s) who are authorized to disclose this information are:

   □ The above named health care provider and/or the custodian for its office records

   □ Other (specify) _____

6. The person(s) who are authorized to receive this information are:
   Names: _____

   Mailing Address: _____
   *(Complete including Zip Code)*

   E-mail Address: _____

2AUTH

PIKEVILLE MEDICAL CENTER

*(form continue on other side)*

7. I acknowledge the following statements:

* I understand that the above named health care provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

* I understand that I may revoke this authorization at any time by notifying the above named health care provider in writing of my intent to revoke this authorization. If I notify the above named health care provider in writing of my intent to revoke this authorization, such revocation will not have any effect on actions taken by it in reliance upon the authorization prior to receiving such notification. Notification of revocation must be addressed to:

**Attention Privacy Officer**
Pikeville Medical Center
911 By Pass Road
Pikeville, KY 41501

* Unless otherwise revoked, I understand that this authorization will expire 180 days from the date of signature.

* I understand that there is potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by Federal law.

* I understand that, upon my request, I may inspect and copy the information to be disclosed pursuant to this authorization before I sign it.

* I understand that, upon my request, I may obtain a copy of my electronic health record in an electronic format and, if I choose to, I may direct to have such copy transmitted directly to an entity or person designated by me, provided that any such choice is clear, conspicuous, and specific.

□ I want a copy of my electronic health record in electronic form.

* I understand that the above health care provider will give me a copy of this authorization form after I sign it.

* If anyone other than the patient whose information is being requested signs this authorization, proof of his/her relationship to the patient and his/her authority to act on behalf of the patient must be provided, such as a copy of durable power of attorney or an Order Appointing Executor/Executrix.

* Kentucky Law allows a patient to receive one (1) free copy of his/her written medical record.
You will be charged up to $1.00 per written page for each additional request.
**There are additional fees for X-Ray film(s).**
**You will be charged the above named health care provider's labor costs in responding to a request for a copy in electronic form.**
**NOTE:** Charges may vary among different providers.

□ I want this as my free copy.

□ I do not want this as my free copy or I (or my designee) have previously received my free copy.

_____ Date:_____ Time:_____
Signature of Patient

_____ _____ Date:_____ Time:_____
Patient's Legal Representative Relationship

_____ Date:_____ Time:_____
Witness

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**