

Medical Record Number: _____
Department Use Only

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION
YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAY BE RETURNED TO YOU FOR COMPLETION

1. Identity: Patient Name: _____ Social Security Number: _____
Address: _____ Date of Birth: _____
Phone number: _____

2. Sender and Receiver:
I authorize disclosure of medical information (as indicated):

From:
(Facility to Disclose Records)

Disclose To: _____

By Mail: _____

I would like to pick up my records. Please call: _____

3. What to disclose: Please check the records you would like disclosed:

HOSPITAL	OUTPATIENT FACILITY/LOCATION
<input type="checkbox"/> Records related to (specify): _____	(Indicate from choices on back): _____
<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Records related to (specify): _____
<input type="checkbox"/> X-Ray Report(s)	<input type="checkbox"/> Out patient notes
<input type="checkbox"/> X-Ray Film(s)	<input type="checkbox"/> Laboratory Report(s)
<input type="checkbox"/> ER Notes	<input type="checkbox"/> OB/GYN Notes/Reports
<input type="checkbox"/> Other: (specify) _____	<input type="checkbox"/> TB screening
<input type="checkbox"/> Operative Report(s)	<input type="checkbox"/> X-Ray Report(s)
<input type="checkbox"/> Pathology Report(s)	<input type="checkbox"/> X-Ray Film(s)
<input type="checkbox"/> Laboratory Report(s)	<input type="checkbox"/> Psychological test report
<input type="checkbox"/> Photo/Video/Other	<input type="checkbox"/> Other: (specify) _____
	<input type="checkbox"/> Pathology Report(s)
	<input type="checkbox"/> Immunization Record
	<input type="checkbox"/> Photo/Video/Other

4. Timeframe: I would like records from the following dates: _____ through _____.

5. Disclosure of special protected records: I authorize the disclosure of information pertaining to:
a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) YES NO/NA
b. The diagnosis or treatment of drug and/or alcohol abuse YES NO/NA
c. Treatment and/or consultation for mental health or psychiatric disorders YES NO/NA

6. Purpose of Use/Disclosure: Please indicate/describe each authorized purpose of the use or disclosure:
 Request of individual Other (specify) _____

7. Expiration date: This authorization will expire in 90 days or _____, which ever occurs last.

- 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 in 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.

Date

Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:
 Minor Incompetent Deceased
Proof of designation must be filed in the chart or sent with this request.

Signature of Legal Representative and Relationship to Patient

Signature of Witness for Psychiatric Records

TO PATIENTS OR LEGAL DESIGNEES:

FACTS ABOUT OBTAINING YOUR MEDICAL RECORDS:

You have the right to obtain a copy of your medical records. The law requires a **signed authorization form** which contains certain criteria included on this form. This form must be **fully completed** before any medical information can be released. Incomplete forms may be returned for completion.

COSTS:

Kentucky law allows you **one free copy** of your medical record. This free copy is one requested by you for yourself or for a third party. Additional requests will cost **\$1.00 per page**. **It is advised you keep a personal copy of any medical information you request to avoid future costs of obtaining copies.**

WHEN AND HOW WILL I GET MY RECORDS?

The request will be completed within **30 days** of receipt. You will be notified via mail if the records cannot be processed in 30 days. If you would like to pick up your records, indicate this on the form with a phone number where you can be contacted. Otherwise, records will be mailed to the address listed on the authorization.

WHERE TO SUBMIT YOUR REQUEST:

Health care services are provided at many different locations and facilities at the University. Each location is responsible for maintaining and releasing its own medical records. **Please be specific as to which records you want.** Address your request to the location your care was received. Sending this authorization to the appropriate area listed below will facilitate our response to you.

<p>Hospital: Inpatient Admits, Outpatient Procedures and/or Emergency Visits</p> <p>Correspondence Section Medical Records Department Room C601 University of Kentucky Hospital 800 Rose Street Lexington, KY 40536-0293 Phone: 859-323-5117 Fax: 859-257-6089</p>	<p>University Health Service (UHS): Student & Employee Health Records</p> <p>University Health Services 830 South Limestone Lexington, KY 40536-0582 Phone: 859-323-5823 x8-3211 Fax: 859-257-8708</p>	<p>Markey Cancer Center Outpatient visits to Markey Cancer Center</p> <p>Markey Cancer Center Whitney Hendrickson Building 800 Rose St., Room 132 Lexington, KY 40536-0098 Phone: 859-257-4488 Fax: 859-257-8931</p>	<p>Radiation Medicine Outpatient visits to Radiation Medicine clinic</p> <p>Radiation Medicine 800 Rose St Room C-1 Lexington, KY 40536-0293 Phone: 859-323-6486 Fax: 859-257-4931</p>	<p>College of Dentistry: Outpatient visits to the College of Dentistry behind the Hospital.</p> <p>College of Dentistry Dental Records 800 Rose Street D-104 Lexington, KY 40536-0297 Phone: 859-323-6294 Fax: 859-323-0271</p>
<p>Main Kentucky Clinic: Outpatient Clinic Visits for: Bluegrass Care Clinic Bluegrass High Risk Obstetrics Cardiology Cardiothoracic Surgery Dermatology ENT/Otolaryngology Family Practice General Medicine General/Vascular/Pediatric Surgery GYN/Oncology Internal Medicine (1st Floor) Medicine Specialties (2nd Floor) Neurology Neurosciences/Neurosurgery Ophthalmology Orthopedics/Sports Medicine Pediatrics Physical Medicine and Rehab Plastic Surgery Rheumatology Urology</p> <p>Health Information Services Kentucky Clinic 740 S. Limestone Room K003 Lexington, KY 40536-0284 Phone: 859-323-5561 Fax: 859-257-7228</p>	<p>Kentucky Clinic South: Outpatient visits for South: Bluegrass Women's Health (OB/GYN) Dentistry Family Practice Pediatrics Preventive Medicine Minimally Invasive Surgery</p> <p>KY Clinic South Medical Records 2400 Greatstone Pointe Lexington, KY 40504 Phone: 859-257-9800</p>	<p>Transplant Center: Solid organ transplant Outpatient clinic visits</p> <p>University of Kentucky Transplant Center 800 Rose Street, Room C401 Lexington, KY 40536-0293 Phone: 859-323-1691 Fax: 859-323-1700</p>	<p>Outpatient Psychiatry: Outpatient Psychiatric visits</p> <p>Outpatient Psychiatry Medical Records 3470 Blazer Parkway 3rd Floor Lexington, KY 40509 Phone: 859-323-6021 Fax: 859-323-4927</p>	<p>Kentucky Clinic Dentistry: Outpatient dental visits to the dental clinics inside the Kentucky Clinic</p> <p>Kentucky Clinic Dentistry Dental Records 740 S. Limestone Room A-219 Lexington, KY 40536-0284 Phone: 859-323-5562 Fax: 859-323-2036</p>
	<p>Kentucky Clinic North: (Now Polk-Dalton Clinic) Dentistry Family Medicine OB/GYN Pediatrics</p> <p>UK Polk-Dalton Clinic Medical Records 217 Elm Tree Lane Lexington, KY 40507 Phone: 859-381-0135 Fax: 859-259-0693</p>	<p>Comprehensive Breast Care Center: Clinic visits to CBCC and all mammogram records including those from KY Clinic South</p> <p>Comprehensive Breast Care Center Whitney Hendrickson Building 800 Rose St. Room 234 Lexington, KY 40536-0098 Phone: 859-323-2222 Fax: 859-323-4667</p>	<p>Radiology/Image Management Actual films/images of X-rays taken at Hospital, KY Clinic and KY Clinic South</p> <p>Image Management 800 Rose St HX-304 Lexington, KY 40536-0293 Phone: 859-323-5416 Fax: 859-257-6769</p>	<p>Hospital Patient Accounts: Hospital Billing Records</p> <p>University of KY Hospital Patient Accounts Dept. 800 Rose St. Room H102 Lexington, KY 40536-0293 Phone: 859-257-8111 or 1-800-288-2779 Fax: 859-257-8071</p> <p>KMSF: Physician Billing Records</p> <p>KMSF 138 Leader Ave. Lexington, KY 40508 Phone: 859-257-8618 Fax: 859-257-8071</p>