# Authorization to Disclose Patient Health Information

Rheumatology Associates PLLC
3430 Newburg Rd.,Suite 250
Louisville, KY 40218

I hereby request a copy of the following patient's medical record:

Full Name of Patient:_____

Maiden Name/Alias:_____ Patient's Birth Date:_____

Information requested (X):

(  ) Entire Medical Record  (  ) Only specified records_____

The above record is to be released to the following individual:

Name and Title:_____ Telephone number: (  )_____

Street Address:_____ City/State/Zip:_____

This record is requested for the following reason (X):

(  ) continued medical care  (  ) legal purposes  (  ) insurance purposes
(  ) personal interest  (  ) other (specify) _____

The authorization must be signed and dated and may be revoked by notifying the practice's office manager in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after that or sooner by my choice, in which case this consent will expire on this date or event _____. Such expiration date or event has not occurred.

Request for record copy release will be handled on a first come, first serve basis.

(  ) Kentucky law directs healthcare providers to furnish a patient one free copy of the Medical Record at patient's request.

(  ) Additional copies provided at $25.00 up to the first 30 pages and $1.00 for each additional page.

I understand that the medical record released pursuant to this authorization could contain information concerning conditions, alcoholism, psychological conditions, psychiatric conditions, and /or bloodborne infectious diseases subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature_____ Date _____

Patient, Parent or Legally Authorized

Representative Relationship to the Patient _____ Telephone number: (  )_____

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentially is protected by federal and/or state law. Federal and state regulations prohibits you ( the recipient) from making any further disclosure without the specific written consent of the person to whom it pertain, or as otherwise permitted by regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

| Staff Signature | Date |
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