Hamburg
1775 Alysheba Way Suite 201
Lexington, KY 40509-2381
Phone: (859) 278-5007
Fax: (859) 278-6867
Email: askfpa@fpalex.com

Patient Name: _____

Street Address: _____

City/State/ZIP:_____

DOB:_____ SSN# _____ Phone # _____

I hereby authorize (Physician, Clinic, Hospital or Other Health Care Provider) to Release Medical Records:

From(Name of party releasing records): _____

Street Address: _____

City, State, ZIP_____

To(Name of party requesting records):_____

Street Address: _____

City, State, Zip _____

Please fill in complete mailing address - ALL records will be mailed

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The information to be released includes:

_____ Entire medical record
_____ Billing Information DATE _____
_____ History&Physical DATE _____
_____ Progress Notes DATE _____
_____ Laboratory Reports DATE _____
_____ Other DATE_____

If the record includes information related to alcohol or drug abuse, mental health diagnosis / treatment, AIDS or other communicable diseases, please check the ones that are applicable.

_____Alcohol/Drug abuse
_____Mental Health Diagnosis/Treatment
_____AIDS/other communicable diseases

I understand that the purpose of this release is for use in:

_____ *Specialty Appointment*
_____ *Insurance Claim Processing*
_____ *Legal Claim Processing*
_____ *Other*

_____ *Change in Family Doctor -(see below)*

Reason: _____ Insurance _____ Closer to home _____Dissatisfied _____Other

I _____am or _____am not transferring my care to another physician/provider other than FPA.

(If I am transferring care, I understand that FPA will no longer be my primary care office.)

Please note that once your Private Health Information is disclosed, it may be redisclosed by the authorized recipient.

Patient/Legal Guardian _____ Date _____

The patient and/or legal guardian may revoke this authorization in writing at any time as per the Notice of Privacy Practices. Release of present and future billing and lab info will be in effect until revoked.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining the authorization if such conditioning is prohibited by the Privacy Rule.

_____If checked, this will be considered the one free copy that you are entitled to according to Kentucky House Bill 250. Please retain this copy for your files and release only a photocopy. In the future, there will be a charge of one dollar per page plus handling charges for additional copies.

DO NOT WRITE BELOW THIS LINE

FPA EMPLOYEE SIGNATURE

_____

COMMENTS_____

_____Released to pt in office/Initials/Date _____