Family Practice Associates of Lexington
1775 Alysheba Way Suite 201
Lexington, KY 40509-2381
Phone: (859) 278-5007
Fax: (859) 278-6867
email: askfpa@fpalex.com
www.fpalex.com

AUTHORIZATION TO DISCUSS/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information (Please Print)

Name: _____

Date of Birth: _____

Telephone Number: _____

Patient Representative Information (Please Print)

By completing this form I authorize Family Practice Associates of Lexington to **discuss** my protected health information and billing information **without restriction** with one or more of the representatives listed below.

THIS FORM DOES NOT ALLOW ACCESS TO COPIES OF MEDICAL RECORDS

Please ensure that the designated individual(s) below can provide the following information about you prior to discussing personal health information and/or sending them to pick up medical forms, prescriptions, etc.

--Patient Legal Name
--Patient Date of Birth

	NAME	RELATIONSHIP	PHONE NUMBER
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I understand there is no expiration date but I may add to, delete from or revoke this entire authorization, in writing, at any time by sending such notification to FPA. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal laws and regulations regarding privacy of my protected health information.

Signature of Patient/Representative _____ Date _____

Witness Signature _____ Date _____
(if signed by Legal Representative)

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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****

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 _____