Owensboro Health

**Owensboro Health Use Only**
MRN:
DOB:
Document Type: Release of Information

## AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**Patient Information**

Patient Name: _____ DOB: _____ Last Four Digits of Social: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

**Method of Receipt/Type of Media (Please check ONLY one)**

☐ MyChart Patient Portal ☐ CD (In Person Pickup by Patient/Other) (encrypted) ☐ CD (by mail) (encrypted)
☐ Fax ☐ USB flash drive (In Person Pickup by Patient/Other) (encrypted) ☐ USB flash drive (by mail) (encrypted)
☐ Paper Copy (In-Person Pickup by Patient/Other) ☐ Paper Copy (by mail) ☐ Email (encrypted)
☐ Email (NOT encrypted) (Note: If you would like us to send information over email not encrypted, this increases the risk that information could be read by an unauthorized third party.)

**Reason or Purpose for the use and/or disclosure of the information**

☐ Continued Care ☐ Legal ☐ Insurance ☐ Disability ☐ Work Comp.
☐ Personal Reasons ☐ Other: _____

**Release Information From:**

_____
(Name of hospital, physician, healthcare provider)
_____
Address City State Zip
_____
Phone Fax

**Release/Send my health information to: ☐ Check this box if same as patient listed above. OR**

_____
(Name of hospital, physician, healthcare provider, other)
_____
Address City State Zip
_____
Phone Fax Email Address

**Information to be released**

Information to be released for the following date range _____ to _____
☐ Hospital Records (Please check the records you would like released)
- ☐ Medical Records Abstract (e.g. H&P, Operative Reports, Consults, Test Reports, Discharge Summary)
- ☐ Discharge Summary ☐ History & Physical ☐ Immunization Record ☐ Emergency Department Reports
- ☐ Operative/Procedure Reports ☐ Pathology Report(s) ☐ X-Ray Report(s) ☐ Lab Report(s)
- ☐ Physical/Occupational Therapy Reports ☐ Billing
- ☐ Other: (specify) _____

☐ Office/Clinic Records (Specify Provider Name): _____
- ☐ Office Billing

Owensboro Health

**Owensboro Health Use Only**
MRN:
DOB:
Document Type: Release of Information

**Release of Special Protected Records**

*I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information concerning the diagnosis or treatment of drug and/or alcohol abuse, treatment and/or consultation for mental health or psychiatric disorders and genetic information.*

**Notice Regarding Delivery Mother's Record**

I understand that if I give birth at Owensboro Health that a portion of my medical records will become part of the newborn medical record.

**Expiration**

This authorization shall become effective immediately and shall remain effective for 120 days from the date of signature.

**Re-Disclosure**

I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it.

**Your Rights**

- I understand that authorizing the disclosure of the information identified above is voluntary. I understand if I refuse to sign that my refusal will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility.
- I understand that I have a right to revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to

| OHRH | OHMCH | OHTLMC |
|---|---|---|
| PO Box 20007 | 440 Hopkinsville St. | 910 Wallace Ave. |
| Owensboro, KY 42304-0007 | Greenville, KY 42345 | Leitchfield, KY 42754 |
| Attn: Health Information Mgmt. | Attn: Health Information Mgmt. | Attn: Health Information Mgmt. |
| Phone: 270-417-6800 | Phone: 270-338-8378 | Phone: 270-259-9517 |

- I understand my revocation will be effective upon receipt and will not apply to information that has already been released in response to this authorization.
- I understand that the revocation will not apply to my insurance company where law provides my insurer with the right to contest a claim under my policy.
- I have the right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).

**Legally Authorized Representative**

If you are requesting records of an adult patient the following will apply:

1) Power of Attorney: Must provide a copy of the POA document.
2) The Executor or Administrator of the adult deceased patient's estate. Must provide a copy of the qualification or order of appointment, signed by a judge as the executor or administrator over the estate.
    - If there is not an estate, court documents noting appointment of a personal representative must be provided.
3) Legal Guardian: Legal Guardian must present an order of appointment, signed by a judge, granting guardianship.

If you are requesting records of a Minor patient the following will apply:

1) Joint legal custody: Parent must provide custody papers.
2) Legal Guardian: Legal Guardian must present an order of appointment, signed by a judge, granting guardianship.

**Signature (As required by law)**

I have read and understand this information. I am the patient or 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.

Signature: _____ Date: _____ Time: _____
(Patient/Legal Representative)

If signed by Legal Representative, print name and relationship.

Name: _____ Relationship_____