

How to Complete the Medical Record Authorization Form

◆ Patient Information

- Enter the patient's First and Last Name, Middle Initial (if any), date of birth, last four digits of Social Security Number, full address, phone number including area code, and patient's email address (optional).

◆ How would you like to receive your records?

- Tell us how you want to receive your records. **Check only one option from the list.**
- If you choose email, we will send the records encrypted to protect your privacy unless you tell us otherwise.

◆ What is the reason for requesting records?

- Select the appropriate reason for requesting records. **Check only one.**

◆ Who do you authorize to release your records?

- Enter the health care provider's full name, address, phone number including area code, and fax number including area code.

◆ Where do you want the records to be sent to?

- Check the box if you want records sent to the patient only. You can skip to the next section.
- If records will be sent to someone other than the patient, enter the recipient's full name, address, phone number, fax number and email address.

◆ What information would you like released? (Check all that apply)

- Tell us the date range when you received your care and which records you want released.
- Mark the box that best describes the type of records you are requesting.
- Please note: Medical Records Abstract includes all pertinent information which includes H&P, Operative Reports, Consults, Test Reports and Discharge Summary.
- Other: Please describe the specific records you're requesting to help us respond more completely to your request. (Example: related to a condition or surgery, specific lab tests, etc.).
- Office/Clinic Records: Select only if you want records from a doctor's office/clinic visit. Please give us the name of your provider to expedite your request.

◆ *The Release of Special Protected records.*

- *By signing this release you are giving permission to release special types of records that are protected separately by law (if they apply). Records 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.*

Authorization for the Use and Disclosure of Health Information (INSTRUCTIONS)



- ◆ Notice Regarding Delivery Mother's Record
 - If you give birth at Owensboro Health a portion of your medical records will become part of the newborn medical record.
- ◆ Expiration Date.
 - This authorization shall become effective immediately and shall remain in effect for 120 days from the date of signature.
- ◆ Re-disclosure.
 - Information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA).
- ◆ Your Rights Under the Law.
 - This section is informational only. It explains your rights under state and federal privacy laws.
- ◆ Legally Authorized Representative.
 - If you are a legally authorized representative of the patient you may be asked to provide additional documents showing that you are the patient or patient's legally authorized representative.
- ◆ Signature and Date.
 - Your signature and date is required for the authorization to be valid. If you are completing the authorization on behalf of the patient, please print your name and your relationship to the patient.

◆ Where to send your request.

OHRH

PO Box 20007
Owensboro, KY 42304-0007
Attn: Health Information Mgmt.
Phone: 270-417-6800
Fax: 270-417-6809
Email: himroi@owensborohealth.org

OHMCH

440 Hopkinsville Street
Greenville, KY 42345
Attn: Health Information Mgmt.
Phone: 270-338-8378
Fax: 270-338-8516

OHTLMC

910 Wallace Ave.
Leitchfield, KY 42754
Attn: Health Information Mgmt.
Phone: 270-259-9517
Fax: 270-259-9589

If you need additional help with completing the Authorization Form, call (270) 417-6800.