HealthCare

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

# AUTHORIZATION FOR RELEASE OF INFORMATION (for Use and Disclosure)

**Please fill out all sections or the form may be returned to you.**

Patient Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

**Type of Release** ☐ **MyChart** ☐ **CD** ☐ **Paper** ☐ **Review records at UK (must make an appointment)**

☐ **Other** _____ ☐ **Pick-up -- Phone number** _____

**Send Information from:**

- ☐ UK HealthCare facilities
- ☐ UK College of Dentistry
- ☐ University Health Service (Includes: UK Student Health / Employee Health / Urgent Care Clinic)
- ☐ Substance Use Disorder Clinic (provide clinic name) _____
- ☐ Other _____

**Send to: email address (for MyChart USE ONLY) or address (if name / address is different from above)**

_____

_____

_____

**Please check the records you would like:** (Can be a very specific date or more general. Example: July 15, 2007 or June 2006 - Feb 2007)

☐ Records related to (specify): _____

(examples: car accident or appendectomy)

| | | | | |
|---|---|---|---|---|
| ☐ Discharge Summary | ☐ Pathology Report(s) | ☐ X-Ray Report(s) | ☐ X-Ray Image(s) | ☐ Photo/Video/Other |
| ☐ TB Screening | ☐ Laboratory Report(s) | ☐ Surgery Reports | ☐ Outpatient Notes | ☐ Psychological Test Report |
| ☐ Immunization Record | ☐ ER Notes | ☐ Other: (specify) _____ | | |
| ☐ Research Records | ☐ All records | | | |

**Sharing of Special Protected Records: I authorize the sharing of information about:**

| | | |
|---|---|---|
| a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) | ☐ YES | ☐ NO / NA |
| b. The diagnosis or treatment of drug and/or alcohol abuse | ☐ YES | ☐ NO / NA |
| c. The treatment and/or consultation for mental health or psychiatric disorders | ☐ YES | ☐ NO / NA |

**Reason records are needed (check all that apply):**

☐ For my care ☐ Social Security/disability ☐ Legal ☐ Personal use ☐ Other (specify) _____

**This Authorization will expire on_____ (date).**

**If no date is included the Authorization will expire in 90 days.**

- I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective except to the extent that the Facility has already used or disclosed information in reliance on the Authorization.

- I further understand that treatment payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.

- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

- 42 CFR part 2 prohibits unauthorized disclosure of these records.

- If the records we produce pursuant to this authorization include HIV or AIDs test results, that information has been disclosed to the recipient from records whose confidentiality is protected by state law. State law prohibits the recipient from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM 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.**

_____ _____

**Date** **Signature of the Patient**

If patient is unable to sign, secure consent of Legal Representative and indicate reason: ☐ Minor ☐ Incompetent ☐ Deceased

_____

**Patient or Legal Representative and Relationship to Patient**

Proof of designation must be filed in the chart or sent with this request.

_____

**Name & ID number of Interpreter, if applicable** **Date**

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# AUTHORIZATION FOR RELEASE OF INFORMATION (for Use and Disclosure)

## TO PATIENTS OR LEGAL DESIGNEES:

### FACTS ABOUT OBTAINING YOUR MEDICAL RECORDS:

You have the right to obtain a copy of your medical records. The law requires **a signed authorization form** which contains certain criteria included on this form. This form must be **fully completed** before any medical information can be released. Incomplete forms may be returned for completion.

### COSTS:

Kentucky law allows you **one free copy** of your medical record. This free copy is one requested by you for yourself or for a third party. Additional requests will cost **$1.00 per page. It is advised you keep a personal copy of any medical information you request to avoid future costs of obtaining copies.**

### WHEN AND HOW WILL I GET MY RECORDS?

Requests will be completed within **30 days** of receipt. You will be notified via mail if the records cannot be processed in 30 days. Records will be delivered as indicated on the request. If you are picking up your records, please note that they will only be held for **30 days** once notice has been made that they are ready for pick-up. If they are not picked up within **30 days of the date of the notice,** the copies will be destroyed and a new request will have to be completed. Please include your phone number so that we may call you when the records are ready for pick-up.

Requests for a copy of your complete record may not be picked up until the request is completed. Please visit our location at 2333 Alumni Drive, Suite 110, Lexington, KY 40517 to pick up the completed request. Walk-in requests may be processed at this location provided the request is for minimal information.

### WHERE TO SEND YOUR REQUEST

**Mail a completed request form to one of the following addresses:**

**1) University of Kentucky Hospital, UK HealthCare Ambulatory Services, UK HealthCare Good Samaritan**
Release of Information Section
Health Information Management Dept.
2333 Alumni Park Plaza
Suite 110
Lexington, KY 40517
Phone: (859) 323-5117

**2) UK College of Dentistry**
Dental Records
770 Rose Street D-104
Lexington, KY 40536-0297
Phone: (859) 323-6675

**3) University Health Service**
(Includes: UK Student Health / Employee Health / Urgent Care Clinic)
830 South Limestone
Medical Records, Room 115
Lexington, KY 40536-0582
Phone: (859) 218-3211

**Or fax a completed request form to:**

| | |
|---|---|
| **University of Kentucky Hospital, UK HealthCare Ambulatory Services, UK HealthCare Good Samaritan** | (859) 218-7658 |
| **UK College of Dentistry** | (859) 323-0271 |
| **University Health Service*** | (859) 257-8708 |

*(Includes: UK Student Health / Employee Health / Urgent Care Clinic)

**Contact UK Health Connection if you have any questions:**
Local (859) 257-1000
Toll-Free (800) 333-8874