

Eastern State Hospital

1350 Bull Lea Road • Lexington, KY • 40511 • 859-246-8000

ESH Patient Itemized Statement Request Form (for Use and Disclosure)

Date: _____ Time: _____ MR# _____

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: ☐ Paper Copies ☐ Discuss Account Information

Send Information from:

☐ ESH Business Office

Send Information to: (if name and address is different from above)

I would like billing records (Itemized Statements) from the following dates: _____ through _____
(This can be a very specific date or more general. Examples: July 15, 2007 or June 2006-February 2007)

Reason records are needed (check all that apply)

☐ For another facility or hospital ☐ 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 eligibility; that my revocation must be submitted in writing; 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 the creating protected health information for disclosure to a third party on my signing this authorization, and facility may condition the provision of the 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.

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.

Date

Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:

☐ Minor ☐ Incompetent ☐ Deceased

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

Signature of Legal Representative and Relationship to Patient