

- 1 University of Kentucky A.B. Chandler Hospital1 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: ————————————————————————————————————	,
City: State: Zip:	Dhana Number
Type of Release TRACQuest CD	Permission to discuss care Review records at UK (must make an appointment)
Send Information from:	Send to: email address (for TRACQUEST USE ONLY) or
UK HealthCare facilities	address (if name / address is different from above)
UK College of Dentistry	address (if flame / address is different from above)
UK Student Health / Employee Health / Urgent Care Clinic	
Other	
I would like records from the following dates: (This can be a very specific date or more general. Please check the records you would like: Records related to (specify):	Examples: July 15, 2007 or June 2006 - Feb 2007)
☐ Immunization Record ☐ Photo/Video/Other ☐ X ☐ ER Notes ☐ Outpatient Notes ☐ A ☐ Surgery Reports ☐ Psychological Test Report ☐ C	
Sharing of Special Protected Records: I authorize the sa. The diagnosis or treatment of AIDS, including the results of Fb. The diagnosis or treatment of drug and/or alcohol abuse c. The treatment and/or consultation for mental health or psychia	HIV tests (the virus that causes AIDS) YES NO / NA YES NO / NA
Reason records are needed (check all that apply): For another doctor or hospital Social Security/disability Legal Personal use Other (specify)	
This Authorization will expire on	
insurance coverage; that my revocation must be submitted in wr submitted/filed this authorization; and that the revocation shall be disclosed information in reliance on the Authorization. - I further understand that treatment payment, enrollment in ar this Authorization, however, Facility may condition the provision information for disclosure to a third party on my signing this Authorization. - I understand that information used or disclosed pursuant to the no longer be protected by applicable privacy law. I further under legal responsibility or liability for the use and disclosure of the at I HAVE READ AND UNDERSTAND THIS INFORMATION. I HA	unless the Authorization was obtained as a condition of obtaining riting to the Registration Office at the Facility/location where I originally e effective except to the extent that the Facility has already used or my health plan, or eligibility for benefits is not conditioned on signing of health care that is solely for the purpose of creating protected health norization, and Facility may condition the provision of research-related his Authorization may be subject to re-disclosure by the recipient and may stand that the facility, its employees, officers and agents are released from cove information to the extent indicated and authorized. VE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE
Date If patient is unable to sign, secure consent of Legal	Signature of Patient
Representative and indicate reason below: Minor Incompetent Deceased Proof of designation must be filed in the chart	Signature of Legal Representative and Relationship to Patien
or sent with this request.	Signature of Witness for Psychiatric Records



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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?

The request will be completed within **30 days** of receipt. You will be notified via mail if the records cannot be processed in 30 days. If you would like to pick up your records, indicate this on the form with a phone number where you can be contacted. Otherwise, records will be mailed to the address listed on the authorization.

WHERE TO SEND YOUR REQUEST

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

1) University of Kentucky Hospital

Release of Information Section Health Information Management Dept. Room C601 800 Rose Street Lexington, KY 40536-0293

2) UK HealthCare Ambulatory Services

Release of Information Section Health Information Management Dept. Room K003 740 South Limestone Lexington, KY 40536-0284

3) UK HealthCare Good Samaritan Hospital

Release of Information Section Health Information Management Dept. Room B128 310 South Limestone Lexington, KY 40508-3008

4) UK College of Dentistry

Dental Records 800 Rose Street D-104 Lexington, KY 40536-0297

5) University Health Service

(Includes: UK Student Health / Employee Health / Urgent Care Clinic) 830 South Limestone Medical Records, Room 115 Lexington, KY 40536-0582

Or fax a completed request form to:

University of Kentucky Hospital (859) 323-6853
UK HealthCare Ambulatory Services (859) 257-7228
UK HealthCare Good Samaritan (859) 226-7037
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