PATTIE A. CLAY REGIONAL MEDICAL CENTER
P.O. Box 1600
Richmond, Ky. .40476
Phone (859) 623-3131

Medical Record Number:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

INSTRUCTIONS: Fill in an answer to each item below. The patient or the patient's Legal Representative must sign this completed authorization before any information will be released.

I, hereby authorize Pattie A. Clay Regional Medical Center to release certain medical information as indicated below

To: _____

_____

_____

PATIENT IDENTIFICATION:

NAME_____ SS#_____

ADDRESS_____ DATE OF BIRTH _____

Information to be released covers the period(s) of hospitalization _____ to _____

and/or outpatient treatment(s) on _____

INFORMATION REQUESTED:

_____ Entire Medical **Record-Excluding HIV/AIDS results**
_____ Face Sheet
_____ Operative Report
_____ Pathology Report
_____ Laboratory Report
_____ Emergency Room Record
_____ Discharge Summary
_____ History and Physical
_____ Radiology Report
_____ Other (specify)_____

I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including the results of HIV tests (virus that causes AIDS)____Yes ___ No Pt. Initial_____
The diagnosis or treatment of drug and/or alcohol abuse ____Yes___ No Pt. Initial_____
Treatment and/or consultation for mental health or psychiatric disorders ____Yes ___ No Pt. Initial_____

REASON FOR REQUEST:

_____ External Review
_____ Insurance
_____ Future Medical Care
_____ Legal Claim

PERSONAL IDENTIFICATION PRESENTED:

_____ Social Security Card
_____ School/Work I.D.
_____ Driver's License
_____ Other

I understand that I may ***REVOKE*** *this release* at any time, in writing, but the request shall remain valid until revoked, or upon sixty (60) days from the date below, whichever occurs first, ***EXCEPT*** to the extent that disclosure made in good faith has already occurred.

The facility, its employees and officers, and attending physician(s) are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

IF PATIENT IS A MINOR - Are you currently divorced or separated from the father/mother? Yes_____ No_____ If you checked yes, you must provide this office with proof of custody before records can be released.

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

_____Minor _____Incompetent _____Deceased _____Other - Explain_____

_____
Signature of Patient

_____
Date of Signature

_____
Signature of Legal Representative and Relationship to Patient

_____
Signature of Witness