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Patient Sticker Place Here

Authorization for the Use and Disclosure of Health Information

Baptist Health Deaconess Madisonville Release of Information

Authorization to Release Protected Health Information

Patient Information: (Please Print)

Name: _____ Med Rec # or Last Four of Social _____

Street Address or PO Box _____

City, State, Zip _____

Phone# _____ Date of Birth _____ E-Mail _____

I, the undersigned hereby authorize and direct:

() Baptist Health Deaconess Madisonville

() Baptist Health Deaconess Medical Group Madisonville

(Doctor's name and office address): _____

and its entities, authorized agents and employees to disclose and deliver a copy of the protected health information described below in accordance with this authorization.

This information may be disclosed to and used by the following individual, organization or agency:

The purpose of this release is: () Continued Medical Care () Legal Purposes () Insurance Purposes () Personal Interest () Other (Specify) _____

Dates to be released: From _____ To _____

The information to be disclosed will include: (check all that apply)

- Entire Medical Record Pathology Cardiac Cath Report
Basic Medical Record Radiology Discharge Summary
Emergency Room Record History and Physical Lab
Face Sheet Operative Report Electronic Format
Other (Specify): _____

I understand that my protected health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse.

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing any substance abuse information under the federal confidentiality requirements for alcohol and drug abuse patient records and the Public Health Service Act. Such information may not be used to criminally investigate or prosecute any alcohol or drug patient. Further, state law prohibits a recipient from making any further disclosure of test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains. A general authorization for the release of medical or other information is NOT sufficient for such purpose.

This authorization will expire upon the occurrence of the following event or condition: _____. If no event or condition is listed, it will expire in 60 days. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to the Hospital's Health Information Management Department. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand that I will be given a copy of this Authorization form, after signing it.

_____ By initialing here, I acknowledge this to be my one and only free copy of my medical record, duplicate pages will be charged \$1.00 per page.

_____ By initialing here, I request my record to be provided in an electronic format on a CD.

Signature of Patient/Authorized Representative (include relationship or nature of authority) _____ Date _____

[] Faxed to: _____ [] Given to: _____ [] Mailed to: _____

To obtain medical records from Baptist Health Deaconess Madisonville, please mail or fax this request to: 900 Hospital Drive Madisonville KY 42431 or Fax 270-824-2036 or 270-825-5942 Call HIM Madisonville for further information: 270-825-5256

