300385

BAPTIST HEALTH DEACONESS MADISONVILLE

Patient Sticker Place Here

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_____

Mark method to receive records: by [ ] by mail (at above address) [ ] by fax _____ [ ] by email _____

I, the undersigned hereby authorize and direct: ( ) Baptist Health Deaconess Madisonville
Baptist Health Deaconess Medical Group ( ) Madisonville ( ) Hopkinsville ( ) Powderly ( ) Dawson Springs
(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	_____ Lab
____ Office Visit Notes	____ History and Physical	____ Discharge Summary	_____ Physician Report
____ Emergency Room Record	____ Operative Report	____ Radiology Image Date of Service_____ & Exam Type_____	
____ Face Sheet	____ Radiology Report	____ Cardiac CATH/ECHO Date of Service_____	
____ Other (Specify):_____			

I understand that my protected health information released 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 if those categories are applicable.
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 substance abuse information under the federal confidentiality requirements for substance abuse patient records as Federal Law 42 CFR Part 2 law prohibits unauthorized disclosure of these records. Such information may not be used to criminally investigate or prosecute a substance abuse 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 following date: _____. If no date is included, the authorization will expire one year from the date of signature. 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 health plan, or eligibility for benefits.

_____ By initialing here, I acknowledge this to be my request for my copy of my legal medical record.

_____ 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

To obtain medical records from Baptist Health Deaconess Madisonville & Medical Group please mail or fax this request to:

BDM Madisonville 900 Hospital Drive Madisonville KY 42431 Fax 270-824-2036 or 270-825-5942 Phone 270-825-5256	BDMMG Hopkinsville 500 Clinic Drive Hopkinsville KY 42240 Fax: 270-707-3367 Phone 270-707-3316	BDMMG Powderly 1010 Medical Center Drive Powderly KY 42367 Fax 270-377-1669 Phone 270-377-1612	BDMMG Dawson Springs 225 Industrial Park Drive Dawson Springs KY 42408 Fax 270-797-3292 Phone 270-797-3521