BAPTIST HEALTH DEACONESS MADISONVILLE

Baptist Health Deaconess Madisonville Release of Information -- Authorization to Release Protected Health Information

By completing and signing this form, I authorize my records to be released as noted below. All records sent by CD and email may be sent securely using encryption or a secure link unless otherwise requested. Due to the risk that information could be potentially intercepted or altered in transit, Baptist Health Deaconess Madisonville strongly recommends using secure or a secure link to transmit patient records in order to promote the confidentiality and integrity of patient information and will only send records via unencrypted/unsecure channels upon patient request.

Patient Info

Patient Full Name:	Previous Last Name:	Date of Birth:
Street Address / City / State / ZIP:		Last 4 digits of SSN#:
Email Address:	Telephone #:	

Release To / Delivery Method

I authorize my records to be released to **one** of the following:

☐ **Myself**: I request Baptist Health Deaconess MDV to release my protected health information to me using the information listed above. Select delivery method below.

☐ **Other person/organization:** I am the patient, or the legally authorized representative of the patient listed above, and request Baptist Health Deaconess to release my protected health information to the person/organization listed below. Please complete the address fields and select delivery method below. (**NOTE**: If the recipient designates an alternative delivery method we will comply to the best of our ability.)

☐ Paper via US Mail ☐ Email (please ensure email is listed) ☐ MyChart (released to parent/patient/legal guardian only)
☐ Fax (must be less than 200 pages) ☐ CD via US Mail

Person:	Organization:	
Street Address:	Fax #:	Telephone #:
City / State / ZIP:	Email Address:	

Purpose

Purpose of Release/disclosure to other person/organization (not required if being disclosed directly to patient):
☐ Continuation of Care / Transfer of Care ☐ Social Security / Disability ☐ Insurance ☐ Criminal Justice System
☐ Attorney / Legal ☐ Personal Use ☐ Other (specify): _____

Information to Release

I am authorizing records to be released from: ( ) Baptist Health Deaconess Madisonville
Baptist Health Deaconess Medical Group ( ) Madisonville ( ) Hopkinsville ( ) Powderly ( ) Dawson Springs
(Doctor's name & office address):_____

DATES OF SERVICE REQUESTED: From_____to_____(if no dates are listed, default will be the past 12 months)

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

☐**Entire Medical Record** ☐**Pathology** ☐**Cardiac CATH Report** ☐**Radiology Image** **Date of Service_____ & Exam Type_____**
☐**Office Visit Notes** ☐**History & Physical** ☐**Discharge Summary** ☐**Cardiac CATH/ECHO Date of Service_____**
☐**Emergency Room Visit** ☐**Operative Report** ☐**Lab**
☐**Face Sheet** ☐**Radiology Report** ☐ **Physician Consult or Progress Notes**
☐**Other (specify):** _____

I understand that the protected health information released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). I also authorize release of records about my behavioral or mental health services, and regarding my substance use disorder treatment, diagnosis, and referral, if those categories are applicable to me.

Parent/Patient/Legal Guardian Authorization

Revoking (cancelling) authorization: I may revoke (cancel) this authorization at any time (unless the purpose of the disclosure is marked as criminal justice system). Revocations (cancellations) must be made in writing and sent to Baptist Health Deaconess Release of Information Department at the address listed on this form. Revocations (cancellations) will not apply to information that has already been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself. **This authorization will expire on_____. If no date is included, the authorization will expire one year from the date of signature**.

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 healthcare provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. 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 is voluntary. I understand that Baptist Health Deaconess will not base treatment, payment, enrollment, or eligibility for benefits by signing this document.

SUBSTANCE USE DISORDER RECORDS. 42 CFR Part 2 prohibits unauthorized disclosure of substance use disorder records released under this authorization. However, if the recipient is a HIPAA covered entity or business associate and is receiving substance use disorder records for treatment, payment, or health care operations, special rules apply. In that event, the substance use disorder records (or information contained in them) may be redisclosed by the recipient in accordance with permissions contained in the HIPAA regulations, but may not be used or disclosed for civil, criminal, administrative, and legislative proceedings against the patient.

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**

BDM Madisonville 900 Hospital Drive Madisonville KY 42431 Fax 270-825-5942 Phone 270-825-5256	BDMMG Madisonville 200 Clinic Drive Madisonville KY 42431 Fax 270-825-7310 Phone 270-825-7358 or 7264	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