Arthritis Center of Lexington
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Medical Release of Information

PATIENT INFORMATION (PLEASE PRINT)

Last Name_____ First Name _____ MI _____

Mailing Address: Street or PO Box _____

City, State, Zip _____

Telephone # _____ Date of Birth _____ S.S. # _____

I hereby authorize (physician, clinic, hospital, or other health care provider)

Release of Medical Records:

From (Name of Party Releasing Records): _____

Mailing Address: Street _____

City, State, Zip _____

To (Name of Requesting Party): _____

Mailing Address: Street _____

City, State, Zip _____

The information to be disclosed includes:

_____ **Entire Medical Record** _____ **History & Physical**

_____ **Progress Notes (last 6 months)** _____ **Laboratory Reports (last 6 months)**

_____ **Other** _____ **X-Rays** _____

Please note that once your Private Health Information is disclosed, it may be re-disclosed by the authorized recipient.

I understand that the purpose of this disclosure is for use in:

_____ **Change of rheumatologist** _____ **Specialty appointment**

_____ **Insurance claim processing** _____ **Other (specify)** _____

_____ **Legal claim processing**

The undersigned Hereby Releases Arthritis Center of Lexington from any and all legal responsibility or liability that could occur from this action.

Patient/Legal Guardian Signature _____ **Date** _____

Witness Signature _____ **Date** _____

The patient/legal guardian may revoke this authorization at any time as per the notice of privacy practices. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining the authorization if such conditioning is prohibited by the Privacy Rule.

_____ **If checked, this will be considered the one free copy that you are entitled to according to Kentucky House Bill 250. Please retain this copy for your files and release only a photocopy. In the future, there will be a charge of one dollar per page plus handling charges for additional copies.**