FAMILY MEDICAL CENTER OF HART COUNTY
P. O. BOX 579, MUNFORDVILLE, KY 42765
HIPAA COMPLIANT AUTHORIZATION TO REQUEST INFORMATION

Patient's name: _____DOB_____SSN:_____

I request and authorize Family Medical of Hart County to release health care information to the person/provider/agency indicated below :

_____
(Person/Provider/Agency name/Address)

This request and authorization applies to:

_____ **Any and all health care records from the last five years**

_____ **Specific health care information** relating to a specific treatment, condition or date(s) of service (state the specific treatment, condition, or date (s) of service) _____

_____**Other (**specify- include dates) _____

_____**X-ray Disk** (specify-include dates) **Type of x-ray** _____ **Date of x-ray** _____

* IMPORTANT*

SEPARATE ACKNOWLEDGEMENT REQUIRED for RELEASE OF SENSITIVE INFORMATION**

Medical information related to alcohol abuse, drug abuse, HIV/AIDS, testing for HIV/AIDS, venereal disease or mental/emotional disorders, is ***protected by Federal and/or State Law.*** This type of medical information requires a separate acknowledgment from the patient/personal representative that this information is to be released and is included in the authorization being made.

Specify the nature of the information to be released:_____

Patient/Personal Representative's initials_____

- I understand that I have the right to cancel this authorization at any time by written notification. Said written notification must include the name or other specific identification of the person(s) that are to no longer receive information, signed and dated by the patient or authorized representative. In lieu of written notification the FMC Revocation of Authorization for Use and Disclosure of Health Care Information form may be completed. I also understand that my cancellation is not effective for any information that may have been released based on this authorization prior to my cancellation of this authorization.

- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires: _____30 days _____ 60 days _____ 90 days _____ 365 days or state a specific date or event below

_____.

Refusal to sign this authorization will not result in the provider conditioning the provision of healthcare. **(Initials)** _____.
This authorization remains on file and I may receive a copy of this form once signed. **(Initials)** _____.

_____ _____
Signature of patient or patient's authorized representative- Date signed Witness Date signed

_____ _____
Name of patient or Personal Representative Relationship

02/ 16/ 2004 bgc, 05/27/2011 bgc, 03/27/15 che

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Additional Elements Only if: The Practice/Provider is requesting the Authorization for His/Her Own Use and Disclosure of the Individuals Health Information.

The purpose of this requested disclosure is: _____

_____

_____

I understand that I may inspect or copy the Protected Health Information to be used or disclosed and will receive a copy of this form once signed. _____
Patient initials

I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the physician conditioning the provision of Healthcare. _____
Patient initials

This disclosure will result in direct or indirect payment to the physician. ____ ____
Yes No

_____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)