Authorization to Disclose Patient Health Information

I hereby request a copy of the following patient's medical record:

Full Name of Patient:_____ Social Security No:_____

Maiden Name/Alias:_____ Patient's Birth Date:_____

Information requested (X):

( ) Entire Medical Record ( ) Only specified records_____

Identify the locations where the patient has been treated (X):

( ) Louisville Oncology, specify location: _____

( ) Norton Community Medical Associates, specify location: _____

( ) Norton Medical Associates, specify location:_____

( ) Norton Immediate Care Center, specify location_____

( ) Other, specify location: _____

Specific year of treatment: _____

The above record is to be released to the following individual:

Name and Title:_____ Telephone number: ( )_____

Street Address:_____ City/State/Zip:_____

This record is requested for the following reason (X):
( ) continued medical care ( ) legal purposes ( ) insurance purposes
( ) personal interest ( ) other (specify) _____

The authorization must be signed and dated and may be revoked by notifying the practice's office manager in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after that or sooner by my choice, in which case this consent will expire on this date or event _____. Such expiration date or event has not occurred.

Request for record copy release will be handled on a first come, first serve basis.

( ) Kentucky law directs healthcare providers to furnish a patient one free copy of the Medical Record at patient's request.

( ) Additional copies provided at $1 per page.

I understand that the medical record released pursuant to this authorization could contain information concerning conditions, alcoholism, psychological conditions, psychiatric conditions, and /or bloodborne infectious diseases subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Note: This item is not required if the disclosure is requested by the patient. A copy of a picture ID must be attached to this authorization form. If Norton Healthcare is asking to use/disclose my information, I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or benefit eligibility. I may inspect or copy any information used/disclosed under this authorization.

Signature_____ Date _____
Patient, Parent or Legally Authorized
Representative Relationship to the Patient _____ Telephone number: ( )_____

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentially is protected by federal and/or state law. Federal and state regulations prohibits you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertain, or as otherwise permitted by regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Staff Signature	Date