CHC
COMMONWEALTH HEALTH CORPORATION

MEDICAL INFORMATION RELEASE AUTHORIZATION

Who is releasing information

- ❑ **The Medical Center**
  250 Park Street
  Bowling Green, KY 42101
- ❑ **The Medical Center at Scottsville**
  456 Burnley Road
  Scottsville, KY 42164
- ❑ **The Medical Center at Franklin**
  1100 Brookhaven Road
  Franklin, KY 42134
- ❑ **The Medical Center at Caverna**
  1501 South Dixie St
  Horse Cave, Ky 42749
- ❑ **The Medical Center at Albany**
  723 Burkesville Road
  Albany, KY 42602
- ❑ **Commonwealth Regional Specialty Hospital**
  250 Park Street
  Bowling Green, KY 42101
- ❑ **The Heart Institute**
  350 Park Street, Suite 210
  Bowling Green, KY 42101
- ❑ **Neuroscience Services**
  825 Second Avenue, Ste. C3
  Bowling Green, KY 42101
- ❑ **Surgical Weight Loss Program**
  825 Second Avenue, Ste. A4
  Bowling Green, KY 42101
- ❑ **Medical Center Urgentcare**
  1110 Wilkinson Trace
  Bowling Green, KY 42103
- ❑ **Bluegrass Outpatient Center / Just for Women**
  1110 Wilkinson Trace
  Bowling Green, KY 42103
- ❑ **Women's Health Specialists**
  350 Park Street, Ste. 203
  Bowling Green, KY 42101
- ❑ **Medical Center Psychiatry**
  A Department of The Medical Center
  Adult Psychiatry
  Child & Adolescent Psychiatry
  350 Park Street, Ste. 204
  Bowling Green, KY 42101
- ❑ **Medical Center Primary Care**
  1901 Scottsville Rd
  Bowling Green, KY 42104
- ❑ **CHC Employee Health Services**
  720 Second Avenue, Ste. 207
  Bowling Green, KY 42101
- ❑ **Primary Clinic at Munfordville**
  1134 Main St. P.O. Box 340
  Munfordville, Ky 42765
- ❑ **Primary Clinic at Caverna**
  1495 South Dixie Street
  Horse Cave, Ky 42749
- ❑ **Infectious Disease & Travel Medicine**
  825 Second Ave. East, Suite C1
  Bowling Green, KY 42101
- ❑ **ENT of Bowling Green**
  340 New Towne Drive
  Bowling Green, KY 42103
- ❑ **Rural Health Clinic**
  466 Burnley Road
  Scottsville, KY 42164
- ❑ **Scottsville Primary Care Clinic**
  217 West Main St.
  Scottsville, KY 42164
- ❑ **Fountain Run Rural Health Clinic**
  47 Akersville Road
  Fountain Run, KY 42133
- ❑ **Barren River Regional Cancer Center**
  103 Trista Lane
  Glasgow, KY 42141
- ❑ **Medical Center Orthopaedics**
  825 Second Ave East Suite C2
  Bowling Green, KY 42101
- ❑ **Rishi Agarwal, M.D.**
  Medical Center Hematology & Oncology
  350 Park St., Suite 206
  Bowling Green, KY 42101
- ❑ _____
  _____
  _____

Patient Identification

Name:_____

Date of Birth:_____SS#_____

Release records to

Name:_____

Address:_____

Phone:_____Fax #:_____

Dates of treatment

Dates:_____

Type of treatment: (may include psychiatric, drug or alcohol abuse)

_____ ER _____ Outpatient _____ Inpatient

Reason for release

_____ Medical Care _____ Insurance _____ Legal Claim

_____ Other, Please explain:_____

_____

Information you want released *(Check what you want)*

_____ H & P _____ DG SUMM _____ OR REPORT

_____ PATH _____ X-RAY _____ ER REPORT

_____ ENTIRE _____ OUTPT

_____ LAB (May include AIDS/HIV information)

_____OTHER _____

_____

_____

Account Number _____

I understand that this authorization is valid only for a maximum of 90 days from the date below, and it covers only treatment prior to the date below.

This information may be released by facsimile machine if request warrants. Commonwealth Health Corporation and its subsidiaries are hereby released from any liability and the undersigned will hold Commonwealth Health Corporation harmless for complying with this authorization. A photostat copy of this authorization is acceptable and will be treated as original.

The undersigned acknowledges that the provision of free medical records by any healthcare provider who receives this release shall fulfill that healthcare provider's obligation to provide one free copy of the medical records, and that any future report request for medical records from the healthcare provider may result in a copying fee up to one dollar per page.

I understand that the information in my health record 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 alcohol and drug abuse.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Revocation date_____ Patient/Legal Representative:_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information comes with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

Patient/Legal Representative Signature: _____ Date:_____

Relationship to patient:_____

Please mail the completed authorization form to:

Attn: Release of Information
Health Information Management Department
The Medical Center
250 Park Street
Bowling Green, KY 42101

FOR OFFICE USE ONLY

❑ Released by: _____

❑ # of pages copied: _____

First free copy: Yes ❑ No ❑