Medical Records Release Form

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH

Medical record #________________________________
Visit Date ______________________________________ **(For Department Use Only)**

INFORMATION

Complete All Information On Form ____ Mail ____Pick-up

Patient's Full Legal Name: ____

Address: ____

Telephone # _________________________________ (Home/Cell) Alternate # __________________________

DOB: _____________________________________ SSN: ____

I hereby authorize Bluegrass Pain Consultants, PLLC or/ ____

To use or disclose my health information, as described below. I further authorize the following individuals or organization (s) to receive my health information:

Name of individual/Facility: ____

The purpose of the requested use or disclosure is: ____ At the request of the individual or

____ Other (please specify) ____

The information to be used or disclosed includes the following specified information:

___Discharge Summary
___History and Physical
___Operative Report
___Radiology Report
___Consultation
___Laboratory Report
___Psychology Evaluation
___All of the above
___Other (Must be specific)
____
____

TIMEFRAME: I would like all records from the following date: _________________ to ________________

I understand that the information in my health record may include information related to sexually transmitted diseases, 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/or drug abuse.

Federal law 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.

The provision of treatment may not be conditioned upon the execution of this authorization unless treatment is provided in conjunction with research or if the purpose of the treatment is solely for disclosing information to a third party (i.e – fitness for work, or life insurances examination).

This authorization will expire upon the occurrence of the following date or condition: _______________. If no date or condition is listed, it will expire in 90 days. I understand that I have the right to revoke this Authorization at any time, and in any order to do so, I must present a written revocation to Bluegrass Pain Consultations, PLLC. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand that I will be given a copy of this Authorization form after signing it.

It is understood that my records may not be released to me at the time requested, and that if I am requesting a copy of my healthcare information at the point of care, that it may be "incomplete" until all healthcare providers have had a chance to complete their documentation in the records. Normal processing time is 7 to 14 days, however it could take up to 30 days from the time I have requested my records. In a case where my physician needs my medical records for an appointment, the medical record department of BPC clinic will send my record after I provide them with my physician's name and number.

____ ____________________

Signature of Patient/Authorized Representative Time/Date

____ ____________________

Signature of Witness if not signed in presence of BPC Time/Date

____ ____________________

Signature of employee verifying identification Time/Date