



1113 Woodland Drive  
Elizabethtown, KY 42701  
270-737-4343  
Fax: 270-769-1072

**Records Release Authorization**

PLEASE FILL OUT COMPLETELY.

DATE \_\_\_\_\_

PATIENT'S FULL NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize EOA to use and/or disclose my protected health information described below to: \_\_\_\_\_ MYSELF OR \_\_\_\_\_.

My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):

\_\_\_\_\_

This authorization for use and/or disclosure applies to the information described below (mark those that apply):

\_\_\_\_ Any and all records in the possession of EOA including mental health, HIV, and/or substance abuse records.

\_\_\_\_ Records regarding treatment for the following condition or injury \_\_\_\_\_ on or about \_\_\_\_\_.

\_\_\_\_ Records covering the period of time \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_ Other (please specify-include dates) \_\_\_\_\_.

I understand that I have the right to revoke this authorization in writing, at any time by sending such written notification to the Medical Records Custodian at EOA. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that EOA may not condition treatment or payment on whether I sign this authorization.

I understand that information used or 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 on \_\_\_\_\_.

SIGNATURE \_\_\_\_\_

I certify that I have received a copy of this authorization.

**STATE LAW ALLOWS A PATIENT TO RECEIVE ONE COPY OF HIS/HER MEDICAL RECORD FREE OF CHARGE. PLEASE READ THE STATEMENTS BELOW AND INITIAL BESIDE THE APPROPRIATE ONE:**

\_\_\_\_ I wish for this to be my free copy of my medical records.

\_\_\_\_ I have already received my free copy and/or do not wish for this to be my free copy. I agree to pay the associated copying charge of \$1.00 per page.