CALDWELL MEDICAL CENTER
Authorization for Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

Address: _____ City: _____ State:_____ Zip:_____

Phone Number: _____

Maiden/Previous Names/Nicknames:_____

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Release Information To:

Name / Facility:_____

Address:_____

City/State/Zip:_____

Phone:_____

For continuing care, fax #:_____

Purpose of Release:

☐ Continuing Medical Care	☐ Workers Comp	☐ Other:_____
☐ Insurance	☐ Disability Determination	_____
☐ Legal Proceeding	☐ Personal	_____

Information to be Released:

☐ Entire Record

☐ Only information related to (specify):_____

_____

☐ Only the service dates from _____ to _____

Release Format: ☐ Paper ☐ CD/DVD **Release Method:** ☐ Mail ☐ Pick Up ☐ Fax (continuing care only)

I understand that I may revoke this authorization at any time by sending a written notice to Caldwell Medical Center, Attention: Medical Records Department, 100 Medical Center Drive, Princeton, Kentucky 42445. However, such revocation shall not be valid to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____.

I hereby authorize Caldwell Medical Center to disclose protected health information concerning the above-named patient to the party identified in the section titled "Release Information To." I understand that the information to be released may include information regarding mental health, alcohol and drug usage/abuse/treatment, and HIV-related information. I understand that once the protected health information is disclosed, the information may be subject to re-disclosure by the recipient and may no longer be protected; provided, however, that the re-disclosure by the recipient of information related to Alcohol and Drug Abuse as defined in 42 CFR part 2 may be prohibited. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment or my eligibility for care.

_____ **Signature of Patient or Patient Representative**	_____ **Date**
_____ **Name of Patient Representative (if applicable)**	_____ **Relationship to Patient** (Parent, Guardian, Attorney-in-fact, etc.)
_____ **Employee Releasing Documentation**	_____ **Date**