3110 Fairview Drive
Owensboro, KY 42303
Phone: 270-240-2129
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AUTHORIZATION FOR RELEASE OF INFORMATION
(for Use and Disclosure)

FACTS ABOUT OBTAINING YOUR MEDICAL RECORDS:
You have the right to obtain a copy of your medical records. The law requires a **signed authorization form** which contains certain criteria included on this form. This form must be **fully completed** before any medical information can be released. Incomplete forms may be returned to you. A personal representative may sign the authorization form as long as he/she has proper authority to do so. When signing as a personal representative please provide Power of Attorney or Executorship as applicable with the signed release.

COSTS:
Kentucky law allows you **one free copy** of your medical record. This free copy is one requested by you for yourself or for a third party. Additional requests will cost **$1.00 per page. It is advised that you keep a personal copy of any medical information you request to avoid future costs of obtaining copies.**

WHEN AND HOW WILL I GET MY RECORDS?
Requests will be completed within **30 days** of receipt. You will be notified via mail if records cannot be processed in 30 days. Records must be picked up from our office, please include your phone number so that we may call you when the records are ready for pick-up. Please note that records will be held for 30 days once notice has been made that they are ready for pick-up. If they are not picked up within **30 days of the date of the notice**, the copies will be destroyed, and a new request will have to be completed.

Patient Full Name:___________________________________ **Social Security Number**:________________
Address:____ **Date of Birth**:________________________
City:____________________ **State**:________ **Zip**:_________ **Phone Number**:_______________________

I authorize my records to be released to **ONE** of the following:
☐**Myself:** I request Advanced Cardiology of Owensboro to release my protected health information to me.
☐**Other Organization**: I am the patient, or the legally authorized representative of the patient listed above, and request that Advanced Cardiology of Owensboro release my protected health information to the organization listed via fax. Please list organization's fax number.
Name of Clinic/Organization____ Address: _______________________
Organization Phone #_______________________ Fax #____________________

I would like records from the following dates: ___________________through ___________________.
(This can be very specific or more general)

I authorize the following information be disclosed:
☐Entire Medical Record ☐ Cardiac Testing Results
☐Office Notes ☐ Lab Results

The purpose records are needed:
☐For another doctor ☐For Social Security/disability ☐Legal ☐Personal use
☐ Other(must specify):____________________

This Authorization will expire ninety (90) days from the date of signature on this form.
-I understand that the protected health information released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about my behavioral or mental health services and treatment I have received for drug and alcohol abuse if those categories are applicable to me.
-Revoking (cancelling)authorization: I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to Advanced Cardiology of Owensboro where I originally submitted/filed this Authorization; and that the revocation shall be effective except to the extent that Advanced Cardiology of Owensboro has already used or disclosed information in reliance on the Authorization.
-I further understand that treatment payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however Advanced Cardiology may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Advanced Cardiology may condition the provision of research-related treatment on my signing this Authorization.
-I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that Advanced Cardiology of Owensboro, its employees, officers, and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.
I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIEVED A COPY OF THIS FORM AND I AM THE PATIENT OR AMM AUTHORIZED TO ACT ON BEHALF OF THE PATIETN TO SING THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

____________________ ____
DATE SIGNATURE OF PATIENT

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SIGNATURE OF LEGAL REPRESENTATIVE AND RELATIONSHIP TO PATIENT