



Facility \_\_\_\_\_

Med Rec # \_\_\_\_\_

Account # \_\_\_\_\_

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACCESS TO PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, [Print Name of Individual], Date of Birth: \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_, hereby authorize \_\_\_\_\_ [Insert Facility Name, See Back]

to use and/or disclose my individually identifiable health information as described below. I authorize the following person(s) or organization \_\_\_\_\_ to receive the information in \_\_\_\_\_ Paper or \_\_\_\_\_ Electronic form.

Street Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

The following individually identifiable health information may be used and/or disclosed:

**Check ( ) all that apply:**

- Discharge Summary       Facesheet       Emergency Room Records       Reports of Lab Tests
- History and Physical Records       Consultation Reports       Reports of X-rays       Operative Reports
- Physical Therapy Notes       All
- Other\*:

Dates of treatment to be released: \_\_\_\_\_

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information: \_\_\_\_\_

**Prohibition on Conditioning of Authorization:** KentuckyOne Health will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

**Re-disclosure:** I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

**Expiration:** This authorization will expire 90 days from the date signed.

**Revocation:** I understand that I may revoke this authorization at any time by notifying KentuckyOne Health in writing by sending a letter to Health Information Management at the specific facility address or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that KentuckyOne Health took before it received my revocation letter. For example, KentuckyOne Health cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

**This Authorization is binding:** The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the KentuckyOne Health's Notice of Privacy Practices.

**I understand a fee may be charged for copies of my medical record.**

**Mail the completed authorization form and a copy of your ID to the appropriate facility address listed on the 2nd page of this authorization.**

**SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE**

**DATE**

Printed name of individual's personal representative, if applicable: \_\_\_\_\_

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian): \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR INTERNAL PURPOSES ONLY**

When KentuckyOne Health is requesting an authorization to use health information for its own use, the following provision must be completed:

**Staff Personnel:**

Received by: \_\_\_\_\_

Date: \_\_\_\_\_

Was a signed copy provided to the individual?      YES      NO  
 Access approved?      YES      NO

ROI Request



F2110

## KentuckyOne Health Guide to Obtaining Medical Records

KentuckyOne Health is the combination of three leading health providers with 20 different facility locations. To assist you with obtaining your medical records in a timely fashion please direct your request to the appropriate facility listed below.

To obtain medical records from the providers listed below mail the completed authorization form and a copy of your id to the address listed:

- KentuckyOne Health – Louisville \*Includes facilities listed below.  
Health Information Management Phone: 1-502-587-4416  
Attn: Release of Information  
P.O. Box 3407, Louisville, Ky. 40201-3407  
\* Jewish Hospital \*University of Louisville Hospital \*Jewish Hospital Shelbyville \*St Mary & Elizabeth Hospital \*Our Lady of Peace \*Frazier Rehab \*Stonecrest Diagnostic \*Cancer and Blood Specialists  
\*Medical Centers South, Southwest, East & Northeast
- St Joseph Lexington Includes East and Jessamine Phone: 1-859-313-1185  
Health Information Management  
Attn: Release of Information  
One Saint Joseph Drive, Lexington, Ky. 40504
- St Joseph Berea Phone: 1-859-986-6555  
Health Information Management  
Attn: Release of Information  
305 Estill Street, Berea, Ky. 40403
- St Joseph Mt Sterling Phone: 1-859-497-5057  
Health Information Management  
Attn: Release of Information  
225 Falcon Drive, Mt Sterling, Ky. 40353
- St. Joseph London Phone: 1-606-330-6678  
Health Information Management  
Attn: Release of Information  
1001 Saint Joseph Lane, London, Ky. 40741
- St. Joseph Martin Phone: 1-606-285-6634  
Health Information Management  
Attn: Release of Information  
11203 Main Street, Martin, Ky. 41649
- Flaget Memorial Phone: 1-502-350-5065  
Health Information Management  
Attn: Release of Information  
4305 New Shepherdsville Road, Bardstown, Ky. 40004
- Physician Office Practice  
Contact the Physician office directly to obtain specific mailing address
- Visiting Nurse Association Phone: 1-502-584-2456  
101 W. Chestnut St, Louisville, Ky. 40202

If you need films from Radiology procedures, you will need to contact the appropriate Radiology Department or Diagnostic Center