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

I, _____, **[Print Name & DOB]** hereby authorize :

Previous Physician: _____

Phone #:_____

Fax #: _____

Address: _____

_____

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:

Kentucky One Obstetrics and Gynecology Associates
170 N. Eagle Creek Drive
Suite 104
Lexington, KY 40509
Phone: 859-967-5848 Fax: 859-967-5473

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

Check (√) all that apply:

__Discharge Summary
__History and Physical Records
__Facesheet
__Consultation Reports
__All
__Reports of Lab Tests
__Reports of X-rays
__Emergency Room Records
__Operative Reports
__ Physical Therapy Notes

__Other*: _____

* If authorization is for *marketing*, indicate if KentuckyOne Health will receive compensation in exchange for the use and/or disclosure of the PHI. ___ YES or NO

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:

_____

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

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.

X_____ _____

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):

_____

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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