GENERATIONS PRIMARY CARE
270 Burley Avenue ♦ Hopkinsville ♦ KY ♦ 42240
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Patient Authorization for Disclosure to Designated Provider
Authorization to Release Medical Record Information

Provider: _____ Patient SS#: _____

Patient Name (please print): _____ DOB: _____

Purpose of Request - I request and authorize the disclosure or release of my protected health information (as identified below) TO/FROM (circle one) following provider:

Name of practice: _____

Name of provider: _____

Address: _____

City, State, Zip: _____

Phone: _____

Description of information to be disclosed – I authorize the disclosure of the following protected health information about me to the person(s) identified above.

_____ Complete medical record (to include any and all information regarding HIV (aids) and testing, sexual abuse, spouse or child abuse, mental illness and substance abuse including controlled substance or alcohol abuse): or

_____ Only the following information: _____

_____

Purpose of disclosure – This protected health information is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

Expirations or termination of authorization – This authorization will expire within _____ days from the date of my signature below.

_____ _____
Patient Signature Date

_____ _____
Signature of Authorized Person Relationship to Patient

_____
For Office Use Only

Date records received _____ Employee initials _____
Date mailed _____ Employee initials _____