Rheumatology Specialists of Paducah

Paducah Rheumatology

100 Kiana Court Ste B Paducah, KY 42001

Phone: (270) 408-6100 Fax: (270) 408-6112

Medical Records Release

I hereby authorize the use or disclosure of my health information as described below, including any personal or confidential information of a sensitive nature, psychological or psychiatric records, and substance abuse, including drugs or alcohol treatment or information pertaining to communicable disease, including HIV status, hepatitis or venereal diseases. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. A photostatic/electronic copy shall be as valid as the original authorization. This information should not be disclosed to any other person or company without further authorization. Other physicians' or outside facilities' records should be requested from their office.

Patient's Name: ____ DOB: ____________________

Phone No.: _________________________ Social Security Number: __________________________________

Address: ____

____

Description of information to be released: ____

____

The purpose or need for this disclosure is: ____

____

Records released from:		Records to be released to:	
Facility Name	_______________________________	Facility Name	_______________________________
Address	_______________________________	Address	_______________________________
Phone & Fax #	_______________________________	Phone & Fax #	_______________________________

I understand that I may revoke this authorization at any time by sending a written notice to Rheumatology Specialist of Paducah. I understand that any release which has been made prior to such revocation that was made in reliance upon this authorization shall not constitute a breach of any rights to confidentiality.

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorize the health care provider to release the information specified to the organization, agency or individual names on this request with the ***EXCEPTION*** of:

_______ Substance abuse
Initials

_______ AIDS/HIV
Initials

_____ Psychological/Psychiatric conditions
Initials

_______ Records relating to any treatment that I paid out of pocket in full.
Initials

☐ I request that my medical records be in electronic format

Signature: ____ Date: ______________________

Relationship to patient if a minor or deceased: ____

This authorization will automatically expire in two years. Staff Initials: _________