Authorization to Disclose Health Information

St. Claire HealthCare
222 Medical Circle
Morehead, KY 40351

Patient Name: _____ Medical Record Number: _____

Date of Birth: _____ Phone Number: _____ Social Security #: _____

1. I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S HEALTH INFORMATION AS DESCRIBED BELOW.

   St. Claire to release to _____
   Address _____
   OR

   Agency _____ Address _____

   to release to St. Claire Medical Center

2. REASON FOR REQUEST

_____	Personal interest	_____	Legal claim processing
_____	Continuity of care	_____	Social Security or Disability claim
_____	Insurance claim processing	_____	Other _____

3. THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS: (include dates where appropriate)

_____	Entire Medical Record	_____	Face Sheet
_____	Emergency Room Record	_____	Pathology Report
_____	Discharge/Clinical Summary	_____	Operative Report
_____	History and Physical	_____	Radiology/Lab Report

   Date of Service _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or records from other healthcare providers. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **Initials:** _____

Please exclude the following information from this disclosure _____ **Initials:** _____

4. **THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:**

   A. I understand that this authorization will expire 60 days from date of signature.

   B. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation**.**

   C. I understand that authorizing the disclosure of this health information is voluntary.

   D. I can refuse to sign this authorization. I do not need to sign this form in order to ensure treatment.

   E. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

5. **I UNDERSTAND THERE MAY BE A CHARGE FOR THIS REQUEST.**

6. RECORDS ARE ROUTINELY MAILED. PERSONAL ID IS REQUIRED WHEN RECORDS ARE PICKED UP. (1 photo ID or 2 other forms of ID).

_____	Social Security Card	_____	School/Work ID
_____	Drivers License	_____	Other (Specify) _____

7. _____ _____
   Signature of Patient or Legal Representative — Date

   _____ _____
   If Signed by Legal Representative, Relationship to Patient — Signature of Witness

***The authorization must be signed by the patient if 18 years of age or over, or by a minor (under 18) if emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent or legal guardian for any other minor or by patient's representative (i.e., power-of-attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court is needed as proof for executor or administrator and a written document is needed as proof of power-of-attorney.**