Kentucky Bone & Joint Surgeons
P 859.276.5008 f 859.278.6401
Patient Authorization to Release Medical Information

Patient Name (Print)	SSN or Health Record Number	Patient DOB
_____	_____	____/____/_____

_____ I authorize Kentucky Bone & Joint Surgeons to use or release/disclose my health information as described below.

1. Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

Please note that KBJS can ONLY release records that were performed/ordered by a KBJS provider.

- ☐ Most recent visit
- ☐ Last 3 visits
- ☐ billing records
- ☐ Operative Report(s) (please describe the dates or body parts you would like the op notes disclosed for):_____
  _____
- ☐ Imaging reports (please describe the dates or body part of images you would like disclosed):
  _____
- ☐ Other (please describe): _____

2. The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe): _____

3. Please initial each item below to indicate your understanding.

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

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

4. Please send the identified information to be used by or released to the following individual(s) or organization(s):

Attn to: _____

☐ Mail to Address: _____

☐ Fax to:_____

☐ I wil pick up the records. Please call me at _____ when they are ready.

This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Patient Signature (or Signature of Person Completing Form if Not Patient*)	**Date**
_____	____/____/_____

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

Witness Signature	Date
_____	____/____/_____