BLUEGRASS COMMUNITY HOSPITAL

RELEASE OF INFORMATION

☐ **Authorization to Allow Release of Information** ☐ **Requisition to Obtain Information** (check one)

Section A: This section is to be completed by the Patient			
Name of Patient:	**Medical Record Number:**	**Social Security Number:**	**Date of Birth:**
Address:			
City:		**State:**	**Zip Code:**

Releasing Facility:	**Facility Name:** Bluegrass Community Hospital		
	Address: 360 Amsden Avenue		
	City: Versailles	**State:** KY	**Zip Code:** 40383
Requesting Facility or Individual	**Requestor Name:**		
	Address:		
	City:	**State:**	**Zip Code:**

Date(s) of Service: thru

☐ Anesthesia	☐ Discharge Summary	☐ Imaging Reports	☐ Physician Orders	☐ All Records
☐ Billing Records	☐ EKG's	☐ Laboratory	☐ Outpatient Records	☐Other:_____
☐ UB92	☐ Emergency Records	☐ Medication Records	☐ Pathology Report	☐_____
☐ Itemized Bills	☐ Face Sheet	☐ Nursing Records	☐ Progress Notes	☐_____
☐ Consultation	☐ History and Physical	☐ Surgery / Progress Notes	☐ Accounting of Disclosure	

The patient or the patient's representative must read / acknowledge the following statements:

- **I understand that the persons hereby authorized to use / disclose information will not condition treatment or payment on my providing this authorization.**
- **I understand that this authorization will expire on**_____(If no date is written, this authorization will expire one year from the dated on which it is received by the hospital)
- **I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to re-disclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164**
- **I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.**
- **I understand that I may see the information described on this form if I ask to see It and I understand that I can receive a copy of this form after I sign it.**
- **I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.**
- **I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.**

_____ _____

Signature of Patient or Legal Representative **date/time**

_____ _____

If a Patient Representative please print name **Basis of Authority to act for patient**

To be completed by Facility Staff

_____ _____

Witness Signature (**of** release and ID verification) **date/time**

ID Verified by Photo ID: ☐ **Yes** ☐ **NO** **Copy Obtained:** ☐ **Yes** ☐ **NO**

Other: _____