LEXINGTON INFECTIOUS DISEASE CONSULTANTS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

I authorize Lexington Infectious Disease Consultants to use and/or disclose my protected health information as described below to _____.

Purpose for disclosure (please circle one): Personal Legal Ongoing Medical Care Other

Patient full legal name: _____ Date of Birth: _____
Patient address: _____ SSN #: _____

This authorization for use and/or disclosure applies to the information described below (check those that apply):

☐ Entire medical record (to include billing, lab results, HIV, radiology, etc.)

☐ Records regarding treatment for the following condition or injury: _____

☐ Records covering specific period of time: _____ to _____

☐ Other (please specify – include dates) _____

I understand I have the right to revoke this authorization by writing to Lexington Infectious Disease, 1720 Nicholasville Road, Ste 602 Lexington KY 40503. I also understand that my revocation will not apply to information that has already been disclosed or used in response to this authorization.

I understand that information given under this authorization should not be disclosed without obtaining my authorization, unless the disclosure is specifically required or permitted by law.
I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

This authorization is effective through (check one):

☐ _____/_____/_____ or

☐ NO Expiration, unless revoked or terminated by the patient or the patient's representative.

Patient's Signature: _____ Date: _____

If Personal Representative, full name: _____

Representative's Signature: _____ Date: _____