University of Kentucky

Authorization for Release of Information (For use and disclosure)

Patient Name_____

Date of Birth _____ Phone number_____ Last four of SSN _____

Mailing Address _____

Request Information From:

☐ UK HealthCare Facilities ☐ UK King's Daughters ☐ UK St. Claire
☐ UK Dentistry ☐ UK King's Daughters Ohio
☐ UK Employee Health
☐ Substance Use Disorder Clinic (Provide clinic name) _____
☐ Other _____

Send Information to: (Name & Address if different than above)

_____ ☐ Pick up
_____ Phone Number _____

Please check the records you would like:

☐ Records beginning on (date): _____ ☐ Hospital stay: From _____ To_____
☐ Radiology reports ☐ Radiology images ☐ Labs
☐ Immunizations ☐ ER Records
☐ Demographic sheet ☐ Discharge Summary
☐ TB Screen ☐ Photo/video
☐ All records (to include nurse's notes, orders, flowsheets, etc.)
☐ Other Please describe: _____

Sharing of special Protected Records: I authorize the sharing of information about

- The diagnosis or treatment of AIDS, including the results of HIV tests ☐ Yes ☐ No/NA
- The diagnosis or treatment of drug and/or alcohol abuse ☐ Yes ☐ No/NA
- The treatment and/or consultation for mental health or psychiatric disorders ☐ Yes ☐ No/NA

Reason records are needed (check all that apply): (Only applicable for recipients other than patient)

☐ For another doctor or hospital ☐ Social Security/Disability ☐ Legal ☐ Personal Use
☐ Other (please specify): _____

***What format are you requesting?**

☐ Paper copy ☐ Deliver to MyChart ☐ USB Thumb Drive ☐ CD ☐ EHI Export (machine readable format)
☐ Electronic copy (Email records using secure file transfer portal. This excludes Radiology Images):
Recipient's Email Address: _____
*Image Records Center (IRC) only releases images via CD or PowerShare.
☐ Review records at _____ (list facility name and must make an appointment)

This Authorization will expire on _____ (date) if no date is included the authorization will expire in 90 days.

- I understand that information made available to a person or entity I designate may no longer be confidential or protected by privacy laws and may be subject to re-disclosure by the recipient.
- I further understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this authorization; however, facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this authorization and facility may condition the provision of research-related treatment on my signing this authorization.
- I understand that I may revoke this authorization at any time, unless the authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Medical Records Department where I originally submitted this authorization, and that the revocation shall be effective except to the extent that the facility has already used or disclosed information in reliance on the authorization.
- This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Signature _____Date/Time_____
Patient or Legal Representative (Proof of representation required)

Relationship, if not patient _____

If patient is unable to sign, secure consent of Legal Representative and indicate reason:
☐ Minor ☐ Incompetent ☐ Deceased

Name & ID number of interpreter (if applicable) _____ Date/Time _____

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AUTHORIZATION FOR RELEASE OF INFORMATION
To patients or Legal Designees:

FACTS ABOUT OBTAINING YOUR MEDICAL RECORDS:
You have the right to obtain a copy of your medical records. A signed authorization form which contains certain criteria is required. This form must be fully completed before any medical information can be released. Incomplete forms may be returned for completion.

If you request an EHI Export of your health information, you will receive protected health information maintained in or transmitted by electronic media to the extent that this is included in a designated record set. Your electronic health information will be made available to you in an electronic machine-readable format that a computer or app can read. This format is different than receiving paper or electronic copies of your medical records.

COSTS:
Kentucky law allows you one free copy of your **medical record**. This free copy is requested by you for yourself or for a third party. Additional requests will cost $1 per page if on paper and up to $6.50 per CD.

Kentucky law allows you one free copy of your **radiological images**. This free copy is requested by you and for yourself or for a third party. Additional requests will cost up to $6.50 per CD.

WHEN AND HOW WILL I GET MY RECORDS?
Requests will be completed within 30 days of receipt. Records will be delivered as indicated on the request. If you are picking up your records, please note that they will only be held for 30 days once notice has been made that they are ready for pick-up. If they are not picked up within 30 days of the date of the notice, the copies will be destroyed, and a new request will need to be completed. Please include your phone number so that we may call you when the records are ready for pick-up.

HIM Department Hours of Operation are Monday through Friday 8 am to 4:30 pm excluding holidays.

WHERE TO SEND YOUR REQUEST (Mail or fax a completed form to):

UK HealthCare - Webpage: https://ukhealthcare.uKY.edu/patients-visitors/patients/medical-records

UK HealthCare
2333 Alumni Park Plaza
Suite, 110
Lexington, KY 40517
Phone: 859-323-5117
ROI Fax: 859-218-7658

UK Dentistry
770 Rose Street, D-104
Lexington, KY 40536
Phone: 859-323-6675
Fax: 859-323-0271

UK Employee Health
830 S. Limestone – Room 124
Lexington, KY 40536
Phone 859-218-3211
Fax: 859-218-8708

UK Healthcare
Department of Radiology, Pavilion H
Image Records Center, Room HX214
800 Rose Street
Lexington, KY 40536
Phone: 859-323-5416
Fax: 859-257-6769

UK King's Daughters
Attn: Medical Records – 2nd Floor
2000 Ashland Drive
Russell, KY 41101
Phone: 606-408-1820
Fax: 606-408-6794
Email: medicalrecords@kdmc.kdhs.us

UK St. Claire
222 Medical Circle
Morehead, KY 40351
Phone: 606-783-6570
Fax: 606-783-6369
Email: SC-healthcarerecords@uky.edu