Complete ALL 4 Steps

AUTHORIZATION FOR RELEASE OF INFORMATION

① Fill In

Patient's Name: _____

Date of Birth: ____/____/____ SSN: ____-__-____ Phone# ( ) -

Address: _____

☐ **FROM: KENTUCKY FAMILY MEDICINE**
706 Maynor Street, Corbin, KY 40701 Phone: 606-261-2032
Fax: 800-880-2213 www.KYFAM.com
TO: Name (Where KFM is sending records to)_____
Address: _____
Ph: _____ Fax:_____

② Fill In Your Previous Provider

☐ **TO: KENTUCKY FAMILY MEDICINE**
706 Maynor Street, Corbin, KY 40701 Phone: 606-261-2032
Fax: 800-880-2213 www.KYFAM.com
FROM: Name (Where KFM is getting records from)_____
Address: _____
Ph: _____ Fax:_____

Specific description/dates/reasons for release: (check all that apply)

☐ Any and all information/records in the possession of KENTUCKY FAMILY MEDICINE, including mental health, HIV/STD, KASPER reports, and substance abuse records.

X Any and all information/records in the possession of the above named other facility, including mental health, HIV/STD, KASPER reports, and substances abuse records.

☐ Dates for release of records: ONLY FROM: ____/____/____ TO: ____/____/____, including mental health, HIV/STD, KASPER reports, and substance abuse records.

☐ Other Specific Requests: _____

This authorization will expire on: ____/____/____ (up to one year from date signed if not noted). I understand that I have the right to revoke this authorization in writing, at any time, by sending written notification to KENTUCKY FAMILY MEDICINE.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by federal laws and regulations regarding the privacy of my protected health information.

_____ _____ ____/____/____

Signature of Patient/Representative Description Representative Date signed

③ Sign ↑ ↑ ④ Date