Medical Records Department
320 Thomas More Parkway
Crestview Hills, KY 41017
Phone: (859) 341-4266
Fax: (513) 487-4203

Authorization for Release of Medical Records

Patient's Full Name (please print) _____ **Patient's Date of Birth** _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. Please indicate the Division of Riverhills Neuroscience authorized to use or disclose information:

____Neurology ____Pain Management ____Diagnostics (MRI)
____Neurosurgery ____PM/Rehabilitation ____All Divisions (except Behavioral Medicine)

2. The specific information that should be disclosed includes*:

____History & Physical ____Labs and/or Test Results ____Physical Therapy
____Progress Notes ____Diagnostic Images on CD ____Procedures
____ Billing Records
____Complete chart (does not include neuropsychology reports, or diagnostic images)
____Records for This Date Range Only:_____
____Other (Please specify): _____

**Charges may apply*

3. The following person or facility may receive disclosure of protected health information about me:

Name _____

Address _____

City, State, Zip Code _____

Phone_____ Fax _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying Riverhills Neuroscience in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

6. My purpose/use of this information is for:
____Continuing Care ____Legal Purposes ____Personal Use ____Other: _____

7. This authorization expires on_____or one year after the date of signature.

8. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV, or AIDS; information related to behavioral or mental health services; drug, alcohol, and substance abuse; and genetic information.

_____ _____ _____
Patient's Signature (or Legal Guardian) Date of Signature Patient's Phone Number

This information is to be disclosed to the above-named person/entity for the above-stated purpose only from records whose confidentiality is protected by state and federal law. Further disclosure of this information without the specific written consent of the person to whom it pertains is prohibited. A general authorization for the release of medical information is understood to be sufficient for this purpose. See 42 CFR Part 2.