Authorization to Disclose Patient Health Information
Joint Endeavors PLLC
127 Fairfax Ave.
Louisville, KY 40207

Phone (502) 890-3899 Fax (877) 591-0879

I hereby request a copy of the following patient's medical record:

Full Name of Patient: _____

Maiden Name/Alias: _____ Date of Birth: _____

Information requested (X):

( ) Entire Medical Record ( ) Only Specified Records: _____

The above record is to be released to the following individual:

Name: _____ Telephone number: _____

Address: _____

The record is requested for the following reason (X):

( ) continued medical care ( ) legal purposes ( ) insurance purposes
( ) personal interest ( ) other (specify): _____

The authorization must be signed and dated and may be revoked by notifying the practice's office manager in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after that or sooner by my choice, in which case this consent will expire on this date or event: _____. Such date or event has not occurred.

Request for record copy release will be handled on a first come, first serve basis.

( ) Kentucky law directs healthcare providers to furnish a patient one free copy of the medical record at the patient's request.

( ) Additional copies are provided at $25.00 for the first 30 pages and $1.00 for each additional page.

I understand that the medical record released pursuant to this authorization could contain information concerning conditions, alcoholism, psychological conditions, psychiatric conditions and/or bloodborne infections subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described as redisclosed and is no longer protected by these regulations. I hereby affirm that I have read and fully understand these statements and consent to the disclosure of the medical record for the purpose and extent stated above

Signature: _____Date: _____

Patient, Parent or Legally Authorized

Representative Relationship to the Patient (X): ( ) Self ( ) Other: _____

Prohibition of redisclosure: the information disclosed to you in these records have confidentiality protected by federal and/or state law. Federal and state regulations prohibit you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by regulations. A general authorization for the release of medical and other information is NOT sufficient for this purpose.

Staff Signature: _____ Date: _____