Casey County Hospital

Authorization for Release of Protected Health Information (PHI)

Mailing address:

Casey County Hospital
187 Wolford Avenue
Liberty, KY 42539

Fax: 606-787-1699
Phone : 606-787-6275 X191

Patient Name_____

Address: _____

Birth Date: ____/_____/_____Telephone Number:_____

I hereby authorize Casey County Hospital to release my protected health information to:

☐ SELF

Name/Organization:_____

Address:_____

Fax # (healthcare providers only)_____

Purpose of disclosure (please check one):

☐ Personal Use ☐ Changing Physicians ☐ Legal ☐ Continuing Care ☐ Other_____

Date of Service for records requested_____

☐ All records	☐ Discharge Summary
☐ Hospital Outpatient Clinic	☐ Radiology Reports
☐ Emergency Department Visit	☐ Immunizations
☐ Laboratory Test / Pathology reports	☐ Medications
☐ Specific Provider notes	☐ Other _____

TO REQUEST THE RELEASE OF SPECIFICALLY PROTECTED OR PROVILEDGED INFORMATION, YOU MUST AUTHORIZE BELOW:

The diagnosis or treatment of AIDS, including HIV Test Results	☐yes	☐no
The diagnosis or treatment of Alcohol and/or Drug Abuse Records	☐yes	☐no
The treatment and/or consultation for mental health or psychiatric disorders	☐yes	☐no
Genetic testing	☐yes	☐no

Per KRS 422.317, patients are entitled to the first copy of their medical records free of charge. Each additional copy shall be $1.00 per page. Records Transferred directly to another healthcare entity are free of charge.

☐I agree to fees listed above and understand the first copy of medical records is free of charge.

I understand that I have the right to revoke this authorization at any time except to the extent Casey County Hospital has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to Casey County Hospital.

I also understand that when information is used or disclosed based on an authorization; the information may be redisclosed by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information.

This authorization shall expire within 365 days from the date of this authorization as identified below.

I understand that I have the right to refuse to sign this authorization and that Casey County Hospital will not condition treatment on the provision of this authorization.

A photocopy of this authorization is to be given the same force and effect as the original.

Signature of Patient_____Date_____

Signature of Legal Representative_____Relationship to Patient_____Date_____