Madison
Family Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: ____
First Middle Last

Date of Birth: ______________________ Social Security Number: ______________________

Address: ____

____
____
____
____
____

MEDICAL RECORDS RELEASE: FROM

Madison Family Clinic
2161 Lexington Road
First Floor - Suite 5
Richmond, KY 40475
Phone: 859-626-7794
Fax: 859-626-7764

MEDICAL RECORDS RELEASE TO:

Information to be released covers the period (s) of hospitalization from ______________ through ______________
and/or outpatient treatments on ______________________________.

1. Specific description, including dates of information to be disclosed (Please check all that apply):
   - ❑ Any and all records in the possession of ____________________ including mental health, HIV and/or substance abuse records.
   - ❑ Records covering the period of time __________________ to __________________
   - ❑ Other (specify): ____
2. Specific purpose of disclosure: ____
3. This authorization will expire on: ____________________ (up to one year from date signed)

I understand that I have the right to revoke this authorization in writing, at any time, by sending written notification to the privacy officer at Madison Family Clinic. I also understand that the revocation will not have any affect on any actions that Madison Family Clinic took before receiving the revocation.

I understand that I do not have to sign this authorization, and that Madison Family Clinic may not condition treatment on or payment on whether I sign this authorization.

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 of Personal Representative

______________________________ Date

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