OWENSBORO
Medical Practice

Main Phone: (270) 683-8672

Date: _____
Medical Records #: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Patient's Name _____ Phone Number: _____

Patient's Date of Birth _____ Patient's Social Security Number _____

I, _____, hereby authorize the following listed clinic(s) to release my medical information, including any records, including those of personal and confidential information of a sensitive nature that may document alcohol and drug abuse records, social and psychological history and treatment, and any information relevant to communicable diseases and infections which include but are not limited to, sexually transmitted disease, tuberculosis, HIV, AIDS, or ARC. I understand that my records are protected under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expires automatically in six (6) months from date of signature. I understand there may be a charge for this request including a charge any films (CDs) requested.

Please release said records from / to:

- ☐ Owensboro Heart & Vascular, 1200 Breckenridge Street, Suite 101, Owensboro, KY 42303, Fax: (270) 685-8233
- ☐ Owensboro Primary Care, 1200 Breckenridge Street, Suite 202, Owensboro, KY 42303, Fax: (270) 685-8233
- ☐ Immediate Care Center, 1200 Breckenridge Street, Suite 103, Owensboro, KY 42303, Fax: (270) 685-8226
- ☐ The McLean Clinic, 215 Hill Street, Livermore, KY 42352, Fax: (270) 278-9221
- ☐ The Muhlenberg Clinic, 1100 West Everly Brothers Blvd, Central City, KY 42330, Fax: (270) 685-8233
- ☐ Owensboro Advanced Sleep Center, 1126 Triplett Street, Suite 101, Owensboro, KY 42303, Fax: (270) 689-2052
- ☐ Owensboro Neurology, 1200 Breckenridge Street, Suite 201, Owensboro, KY 42303; Fax (270) 691-1851
- ☐ Rejuve, 1200 Breckenridge Street, Suite 201, Owensboro, KY 42303, Fax: (270) 691-1851
- ☐ VORA Wound Healing Center, 1200 Breckenridge Street, Suite 201, Owensboro, KY 42303; Fax: (270) 691-1842

Please release said records from / to:

☐ _____

_____

_____

Phone: _____

Type of information to be disclosed and dates of services:

Office Note: _____ Date: _____
Laboratory results: _____ Date: _____
Medication List: _____
Entire Medical Record: _____
Records covering time period from _____ to _____

Testing Records of: _____ (date) Circle One
SPECT, Treadmill, Echo, U/S Gallbladder, U/S Renal
U/S Abdomen, U/S Extremities, Holter, EBA, EKG,
Sleep Studies, Therapy Treatment, Other testing: _____

Other: _____
_____

Reason for request: _____

Signature of Patient
or Authorized Representative _____ Date _____

OMP Staff: Patient Identity confirmed with photo ID? _____ Yes
Power of Attorney Paperwork (if applicable): _____ Yes
Employee Signature: _____ Date: _____