KentuckyOne Health™

Facility _____

Med Rec # _____

Account # _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACCESS TO PROTECTED HEALTH INFORMATION

I, _____ **, [Print Name of Individual],** Date of Birth: _____

Last 4 digits of SSN: _____, hereby authorize _____ **[Insert Facility Name, See Back]**

to use and/or disclose my individually identifiable health information as described below:

I authorize the following person(s) or organization to receive the information in ____ Paper or ____ Electronic

_____

Street Address:_____ Telephone #:_____

City, State, and Zip Code: _____

The following individually identifiable health information may be used and/or disclosed:

Check () all that apply:

____ Discharge Summary ____ Facesheet ____ Emergency Room Records ____ Reports of Lab Tests
____ History and Physical Records ____ Consultation Reports ____ Reports of X-rays ____ Operative Reports
____ Physical Therapy Notes ____ All
____ Other*: _____

* If authorization is for , indicate if KentuckyOne Health will receive compensation in exchange for the use and/or disclosure of the PHI.
____ YES or ____ NO

Dates of treatment to be released: _____
I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

_____

I understand a fee may be charged for copies of my medical record

Prohibition on Conditioning of Authorization: KentuckyOne Health will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire 90 days from the date signed.

Revocation: I understand that I may revoke this authorization at any time by notifying KentuckyOne Health in writing by sending a letter to Health Information Management at the specific facility address or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that KentuckyOne Health took before it received my revocation letter. For example, KentuckyOne Health cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the KentuckyOne Health's Notice of Privacy Practices.

_____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE **DATE**

Printed name of individual's personal representative, if applicable:_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

Witness: _____ Date:_____

ROI Request

F2110

FOR INTERNAL PURPOSES ONLY

When KentuckyOne Health is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? YES NO
Access approved? YES NO

KentuckyOne Health Guide to Obtaining Medical Records

KentuckyOne Health is the combination of three leading health providers with 20 different facility locations. To assist you with obtaining your medical records in a timely fashion please direct your request to the appropriate facility listed below.

To obtain medical records from the providers listed below mail the completed authorization form and a copy of your id to the address listed:

- Jewish Hospital & St Mary's Healthcare - includes Jewish Hospital (JH)Downtown, JH Medical Center's Northeast. East, South. Southwest, JH Shelbyville, Stonecrest Diagnostic, St Mary & Elizabeth Hospital, Our Lady of Peace* and Cancer Blood Specialists. *Includes Peace Counseling Services
  Health Information Management Phone: 1-502-587-4416
  Attn: Release of Information
  P.O. Box 3407, Louisville, Ky. 40201-3407
- University of Louisville Hospital / James Graham Brown Cancer Center Phone: 1-502-562-3372
  Health Information Management
  Attn: Release of Information
  530 S. Jackson Street, Louisville, Ky. 40202
- St Joseph Lexington Includes East and Jessamine Phone: 1-859-313-1185
  Health Information Management
  Attn: Release of Information
  One Saint Joseph Drive, Lexington, Ky. 40504
- St Joseph Berea Phone: 1-859-986-6555
  Health Information Management
  Attn: Release of Information
  305 Estill Street, Berea, Ky. 40403
- St Joseph Mt Sterling Phone: 1-859-497-5057
  Health Information Management
  Attn: Release of Information
  225 Falcon Drive, Mt Sterling, Ky. 40353
- St. Joseph London Phone: 1-606-330-6678
  Health Information Management
  Attn: Release of Information
  1001 Saint Joseph Lane, London, Ky. 40741
- St. Joseph Martin Phone: 1-606-285-6634
  Health Information Management
  Attn: Release of Information
  11203 Main Street, Martin, Ky. 41649
- Flaget Memorial Phone: 1-502·350-5065
  Health Information Management
  Attn: Release of Information
  4305 New Shepherdsville Road, Bardstown, Ky. 40004
- Physician Office Practice
  Contact the Physician office directly to obtain specific mailing address
- Visiting Nurse Association Phone: 1-502-584-2456
  101 W. Chestnut St, Louisville, Ky. 40202

If you need films from Radiology procedures, you will need to contact the appropriate Radiology Department or Diagnostic Center