King's Daughters

UK King's Daughters
King's Daughters Ohio
King's Daughters Family Care Centers
King's Daughters Urgent Care Centers
King's Daughters Medical Specialties

Authorization for Release of Information

Name _____

Date of Birth _____ Phone number_____ Last four of SSN _____

Mailing Address _____

Please check the records you would like:

☐ Records beginning on (date): _____
☐ Hospital stay: From _____ To_____
☐ Radiology reports ☐ Radiology images ☐ Immunizations ☐ Demographic sheet
☐ Immunizations ☐ All records (to include nurses notes, orders, flowsheets, etc.)
☐ Other Please describe: _____

Sharing of special Protected Records: I authorize the sharing of information about

- The diagnosis or treatment of AIDS, including the results of HIV tests ☐ Yes ☐ No/NA
- The diagnosis or treatment of drug and/or alcohol abuse ☐ Yes ☐ No/NA
- The treatment and/or consultation for mental health or psychiatric disorders ☐ Yes ☐ No/NA

Reason records are needed (check all that apply): (Only applicable for recipient other than patient)

☐ For another doctor or hospital ☐ Social Security/disability ☐ Legal
☐ Other (please specify): _____

Who is to receive the requested information?

☐ Picked up by you in person (you will receive a phone call when the records are ready for pickup).
☐ Picked up by someone you choose. If yes, who? _____
☐ Mailed to your home (address above will be used unless notified)
☐ I am requesting a copy be made available to the following person or entity: (please specify the recipient's name and address)_____
☐ By encrypted e-mail (File over a certain size may not be available for e-mail).
Email address _____
☐ By unencrypted e-mail ***note**: if you select this option there is a risk that the records could be read or accessed by someone else during transmission.* _____

What format are you requesting?

☐ Paper copy ☐ USB thumb drive ☐ Deliver to My Chart
☐ Review records at King's Daughters (must make an appointment) ☐ Permission to discuss care
☐ Electronic copy (records will be provided on a CD unless email is requested).

- I understand that information made available to a person or entity I designate may no longer be confidential or protected by privacy laws and may be subject to re-disclosure by the recipient.
- I further understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this authorization; however, facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this authorization and facility may condition the provision of research-related treatment on my signing this authorization.
- KDMC will rely on this request to make this information available as outlined above and cannot be held liable for any information released on my request.
- This form expires when the records have been released or viewed.
- I understand that I may revoke this authorization at any time, unless the authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Medical Records Department where I originally submitted this authorization, and that the revocation shall be effective except to the extent that the facility has already used or disclosed information in reliance on the authorization.

Signature _____Date_____
Patient or Legal Representative (Proof of representation required)

Relationship, if not patient _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

To patients or Legal Designees:

FACTS ABOUT OBTAINING YOUR MEDICAL RECORDS:
You have the right to obtain a copy of your medical records. The law requires a signed authorization form which contains certain criteria included on this form. This form must be full completed before any medical information can be released. Incomplete forms may be returned for completion.

COSTS:
Kentucky law allows you one free copy of your medical record. This free copy is requested by you for yourself or for a third party. Additional requests will cost $1 per page if on paper and $5 per disc if requested electronically.

WHEN AND HOW WILL I GET MY RECORDS?
Requests will be completed within 30 days of receipt. Records will be delivered as indicated on the request. If you are picking up your records, please note that they will only be held for 30 days once notice has been made that they are ready for pick-up. If they are not picked up within 30 days of the date of the notice, the copies will be destroyed and a new request will have to be completed. Please include your phone number so that we may call you when the records are ready for pick-up.

WHERE TO SEND YOUR REQUEST
Mail a completed form to:
UK King's Daughters
Attn: Medical Records
2201 Lexington Ave
Ashland, Ky 41101

Fax a completed request to: 606-408-6794

Email a completed request to: medicalrecords@kdmc.kdhs.us

Send an electronic request through your My Chart.

Contact the Medical Records Department if you have any questions:
606-408-1820