

RELEASE OF MEDICAL/PSYCHIATRIC RECORDS

Name: _____

Date of Birth: _____

Social Security Number: _____

Information contained in your records could be considered privileged, sensitive or embarrassing. With your signature, you agree that this practice and/or your physician are not negligent or responsible for any illness or problems related to the release of this information. It is understood that this authorization for release of information is subject to revocation at any time in writing.

Pursuant to KRS 422.317, you, your attorney or your authorized representative is entitled to one free copy of your medical records. Thereafter, you, your attorney or your authorized representative will be charged \$1.00 per page for each additional copies.

Prohibition of Redislosure

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, Part 3). The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR, Part 3. A general authorization for this release of medical/psychiatric records or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patients who test positive for AIDS/HIV. KRS 214.181(5)(c)9.e.

I request information to be released from:

Lexington Psychiatric Group, PSC
Charles I. Shelton, D.O.
1030 Monarch Street, Suite 100
Lexington, KY 40513
T: 859-296-0066 F: 859-296-1155

to: _____

Or

to: Lexington Psychiatric Group, PSC
Charles I. Shelton, D.O.
1030 Monarch Street, Suite 100
Lexington, KY 40513
T: 859-296-0066 F: 859-296-1155

Information to be released:

Medical/Psychiatric records and information

Purpose of release:

Correspondence/Records release

Other (please specify): _____

The undersigned hereby authorizes the release of information from the medical health record of:

Patient Name (please print)

Witness Name (please print)

Patient Signature

Witness Signature

Date

Date