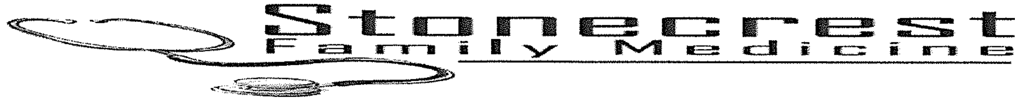

101 Stonecrest Rd, Ste 3 • Shelbyville, KY 40065
(502) 633-5565 • Fax (502) 633-5154
Ronald Creque, MD • Paul Goodlett, MD • Dana Kuhn, PA • Christy Coleman, PA

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Full Patient Name:____________________

Patient Address:____________________ City & State:__________ Zip Code:________

Patient's Date of Birth:____________________ Patient's Social Security Number:____________________

Information to be released:
This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol related conditions and HIV or AIDS related conditions.

Date of Service or date range requested:____________________

☐ Entire Medical Record
☐ Specific Portion of Medical Record, including:____________________

Requesting Information be submitted from:____________________

Address:____________________ City & State:__________ Zip Code:________

Phone Number:____________________ Fax Number:____________________

The Above Information is to be Released to:

Name & Title:____________________

Address:____________________ City/State:__________ Zip Code:________

Phone Number:____________________ Fax Number:____________________

Purpose of the Disclosure: ____________________
This authorization is effective through (check one):

☐ _____/_____/_____ or ☐ NO Expiration, unless revoked or terminated by the patient or the representative.

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to Stonecrest Attn: Privacy Officer; 101 Stonecrest Rd, Ste 3; Shelbyville,KY 40065. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.
I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

____
Name of patient or Personal Representative (Type/Print)

____________________ ____________________
Signature of Patient or Personal Representative Date

In Office:
Request Completed Date:____________________ By:____________________
Completion Method: ☐Paper ☐ Electronic ☐CD
Records Received at Stonecrest Date:____________________ By:____________________