CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the Practice, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient Name: _____ DOB: _____

Address: _____
(Street) (City) (State) (ZIP)

Type of Release Authorization:

☐ I authorize Advanced Internal Medicine to **RELEASE** Medical Records information **TO**:

☐ I authorize Advanced Internal Medicine to **OBTAIN** Medical Records information on me **FROM**:

_____ Phone: _____

_____ Fax: _____

_____ Please fax all records to (270) 443-0660 or mail records to Advanced Internal Medicine, 2605 Kentucky Ave, Suite 402, Paducah, KY 42003

Specific Information to be Released:

_____ Medical Record from (insert date) _____ to (insert date) _____

_____ Entire Medical Record: including hospitalization or outpatient care, emergency room visit, drug and alcohol treatment care, infection with human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), psychiatric care.

_____ Other: _____

This consent permits the Practice to use and disclose my health information to carry out treatment, payment or healthcare operations. Additional information regarding the uses and disclosures of health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state laws and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records

_____ I permit this confidential information to be released for the following purpose: continuing medical treatment, litigation for review, and/or insurance review.

Patient's Name (Printed) _____

Signature of Patient _____ Date _____

Signature of legally authorized person _____

A request may take several working days to process. If there are questions, please contact Advanced Internal Medicine at (270) 366-7650.