1532 Lone Oak Rd | Suite 315
Paducah, KY 42003
P: 270-538-5880 F: 270-538-5870

Western Kentucky Kidney Specialists

Medical Record Release

I hereby authorize the use or disclosure of my health information as described below, including any personal or confidential information of a sensitive nature, psychological or psychiatric records, and substance abuse, including drugs or alcohol treatment or information pertaining to communicable diseases, including HIV status, hepatitis or venereal diseases. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. A photostatic/electronic copy shall be as valid as the original authorization. This information should not be disclosed to any other person or company without further authorization. Other physicians' or outside facilities' records should be requested from their office.

Patient's Name: _____ **Birth Date:** ____/____/_____

Phone Number: _____ **Social Security:** _____-_____-_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Description of information to be released: _____

The purpose or need for this disclosure: _____

Records Released From:

Facility Name: _____

Address: _____

Phone & Fax: _____

Records to be Released To:

Facility Name: _____

Address: _____

Phone & Fax: _____

I understand that I may revoke this authorization at any time by sending a written notice to Western Kentucky Kidney Specialists, I understand that any release which has been made prior to such revocation that was made in reliance upon this authorization shall not constitute a breach of any rights to confidentiality.

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorize the health care provider to release the information specified to the organization, agency or individual named on this request apart from:

_____ Substance Abuse _____ AIDS/HIV

☐ **I request that my medical records be in electronic format**

Signature: _____ **Date:** _____

Relationship to patient if a minor or deceased: _____

For Office Use Only

Staff Initials: _____ **Date Received:** _____

Released Via: _____ **Date Released:** _____