



Authorization to Disclose Protected Health Information  
The undersigned authorizes

Bluegrass Orthopaedics  
3480 Yorkshire Medical Park, Lexington, KY 40509  
(P) (859) 263-5140 (F) (859) 787-0540

to release my health information as noted below:

**Patient Information**

Patient Full Name: \_\_\_\_\_ Other Names? \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Release Information To**

Email address for record delivery: Please ensure the email address is legible!

\_\_\_\_\_

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax #: \_\_\_\_\_

Purpose of Request:  Personal  Treatment  Legal  Insurance  Transfer  Other: \_\_\_\_\_

**Information to be Released**

If you fail to specify, a 1-year abstract will be provided.

- Please release a **1-year abstract** of my records (includes most recent notes, labs, procedures & testing)
- Please release a **2-year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)
- Date Range: \_\_\_\_\_:
- Progress Notes  Radiology Reports  Labs
- Operative Reports  Injections  Physical Therapy
- Other: \_\_\_\_\_

**(Please pick ONE delivery option)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Send by Email | <input type="checkbox"/> Fax to Doctor | <input type="checkbox"/> Records on Paper |
| <input type="checkbox"/> Records on CD |  |   |

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Kentucky Statute: (803 KAR 25:160)

**Authorization to Release Protected Health Information**

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. \* \_\_\_\_\_ (Please Initial)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** \_\_\_\_\_ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.



Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released; we may be unable to fulfill this request.

Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

\* For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.