RELEASE OF INTEGRATED MEDICAL RECORDS CONSENT

Your privacy and health information are very important to us. Please complete the following consent if you wish to release your medical records to or from our practice. Please contact our Medical Records Department if you need any assistance ***423-784-5771 ext 328***

PATIENT

Name _____ Date of Birth _____ Last 4 digits of SSN: _____

GET RECORDS FROM

Provider or Facility _____ Phone/ Fax#_____

Address _____

DATES AND INFORMATION REQUESTED

Dates of Treatment Requested: _____ Expiration Date: _____

[ ] All
[ ] Hosp Notes-H&P,Operative,Discharge
[ ] Prenatal Records / Labor & Del Note
[ ] Emergency Dept Visit Notes
[ ] Progress Notes/Office History
[ ] Pain Management Notes
[ ] Psychological Test Report(s)
[ ] Laboratory and Path Report(s)
[ ] Radiology Reports(s)
[ ] Medication Lists
[ ] Consultant Evaluation(s)
[ ] Immunizations Records
[ ] Physicals – School
[ ] Reports: Mammo Pap C-scope
[ ] Other:

INFORMATION EXEMPTION

Do Not Send the following: _____

REASON FOR REQUEST

[ ] Transfer of Care
[ ] Consult Appointment
[ ] Continuity of Care
[ ] Insurance
[ ] WIC/ Food Stamps
[ ] Workman's Comp
[ ] Disability
[ ] OB Case Management
[ ] Legal – specify:
[ ] Other:

SEND RECORDS TO

[ ] Dayspring Health
402 Cumberland Ave
Williamsburg, KY 40769
Phone # (423) 784-5771
Fax # (423) 784-6185

[ ] Dayspring Dental
640 W. Hwy 92 Ste. 3
Williamsburg, KY 40769
Phone # (606)765-6080
Fax # (606)-371-5335

[ ] WISD – School Clinic
402 Cumberland Ave
Williamsburg, KY 40769
Phone # (423)-784-5771 ext. 701
Fax # (606)-371-5343

[ ]
Address:

Phone #
Fax #

I hereby certify that I am at least 18 years of age and I give consent to release to the above facility all my medical records requested including any specially protected records such as those related to psychological or psychiatric impairments, substance use, alcoholism, or HIV infection, unless otherwise noted or exempted. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

_____ _____ _____

Signature of Patient, Parent, or Authorized Representative **Relationship to Patient** **Date**

OFFICE USE

Provider Approval and Date: _____ Date Sent Out: _____ Date Records Received: _____