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: _______________________

Record Exemptions: ____

[ ] 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 C-scope
[ ] Other:

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 Jellico
550 Sunset Trail
Jellico, TN 37762
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
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. I understand that my substance use disorder treatment records, if any, are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise required for by the regulations, by other applicable law, or by an Order of a court. I also understand that by authorizing release of Medical Records, there may be some limited information included about substance use and/or behavioral health diagnosis and treatment in the medical record. 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 redisclosure by the recipient on this request and will no longer be protected by federal regulations.

____ ____________________________ ___________

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

OFFICE USE

Provider Approval and Date: ________________ Date Sent Out: __________ Date Records Received: _______