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 ***606-549-2656 ext.328***

PATIENT INFORMATION		
Name:		
Phone #:	**Date of Birth:**	**Last 4 of SSN:**

GET RECORDS FROM:		
Provider/Facility:	**Phone#:**	**Fax#:**
Address:		

DATES AND INFORMATION REQUESTED		
Dates Requested:	**Record Exemptions:**	
[ ] All	[ ] Pain Management Notes	[ ] Immunizations Records
[ ] Hosp Notes-H&P, Op Note, Discharge	[ ] Psychological Test Report(s)	[ ] Immunizations Records
[ ] Prenatal Records / Labor & Del Note	[ ] Laboratory and Path Report(s)	[ ] Mammo [ ] Pap [ ] C-Scope
[ ] Emergency Dept Visit Notes	[ ] Radiology Reports(s)	[ ] Other:
[ ] Progress Notes/Office History	[ ] Consultant Evaluation(s)	

REASON FOR REQUEST		
[ ] Transfer of Care	[ ] Disability	[ ] Legal – specify:
[ ] Consult Appointment / OB Care	[ ] WIC/ Food Stamps	
[ ] Insurance	[ ] Workman's Comp	

SEND RECORDS TO				
[ ] Dayspring Medical	**[ ] WISD – School Clinic**	**[ ] Dayspring Dental**	**[ ] Dayspring Radiology**	**[ ] Other**
Phone# (606) 549-2656	Phone # (423)784-5771	Phone # (606)765-6080	Phone #606-485-2755	
Fax # (423) 784-6185	Fax # (606)371-5343	Fax # (606)371-5335	Fax# (606)328-5364	
Address: 1047 South Hwy 25-W, Williamsburg, KY 40769				

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:** __________ **Date Records Received:** _______