Cumberland Gastroenterology, P.S.C.
(606) 677-2913 Fax: (606)677-6983

Authorization for Release of Information

Signed authorization is necessary to release or obtain medical records. By signing this authorization you are giving Cumberland Gastroenterology permission to release/obtain medical records pertinent to your continued care.

Patient Name: _____
First Middle Initial Last Maiden or Other Name
Date of Birth: _____ SS: _____

Address: _____
Street address City, State and Zip Code
Day Phone _____ Evening phone _____

I hereby authorize Cumberland Gastroenterology to ***obtain*** information from my medical record from _____as indicated below to:

Information to be released/requested may include:

- ☐ History and Physical exam
- ☐ Progress Notes
- ☐ Lab reports
- ☐ X-ray reports
- ☐ Operative note and Pathology
- ☐ Substance Abuse including alcohol/drug abuse
- ☐ Mental Health including psychotherapy notes
- ☐ HIV related information (AIDS related testing)
- ☐ Other_____

I authorize Cumberland Gastroenterology to ***release*** information from my medical record to: _____.

I request my records to be ☐faxed to _____ ☐ electronically sent ☐pick up paper copy

Purpose of Disclosure: ☐ Continued Care ☐ Consultation/second opinion ☐ Insurance
☐ Changing Physicians ☐ Legal ☐ Other (Please specify)
_____

1. I understand this authorization will expire in one year.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that I am being requested to release this information by Cumberland Gastroenterology for the purpose of medical care.
    a. By authorizing this release on information, my health care and payment for my health care will not be affected if I do not sign this form.
    b. I understand I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.
    c. I have been informed that Cumberland Gastroenterology will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with Kentucky statute, I will pay the fee for such records. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____
Signature of Patient or legal guardian Date