ADVANCED PRIMARY & BEHAVIORAL HEALTH
789 EASTERN BY-PASS, STE 10
RICHMOND, KY 40475

Phone (859)624-2290
Fax (859) 624-5455

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Lat 4 digits of Social Security No: _____

I authorize APBH to obtain my health information as described below from/to the following (Please include full name of the doctor or practice name.)

1. _____ 2. _____

3. _____ 4. _____

(CHECK ONE) The purpose of the requested use or disclosure:

_____ Continuation of Care (changing doctors) _____ Personal _____ Legal ____ Insurance

THE INFORMATION TO BE USED OR DISCLOSED INCLUDES THE FOLLOWING SPECIFIED INFORMATION:

____ Discharge Summary ____ Consultation Reports ____ ED Records

____ History and Physical ____ Nursing Notes ____ Progress Notes/Orders

____ Operative Report ____ Lab Reports ____ Other (specify)

____ Pathology Report ____ Radiology Reports _____

Dates of Treatment to be released from _____ to _____ (please specify dates)

Sharing of Special Protected Records: I authorize the sharing of information about:

- **The diagnosis or treatment of AIDS, including the results of HIV testing ___ YES ___ NO**
- **The diagnosis or treatment of drug and/or alcohol abuse ___ YES ___ NO**
- **The treatment and/or consultation for mental health or psychiatric disorders ___ YES ___ NO**
- **I understand that this authorization shall be valid through _____ (date), but that I may revoke it in writing or any time; any such revocation shall have no effect on disclosures made previously.**
- **I understand that I have the right to inspect and copy the information to be released.**
- **I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.**
- **I understand that the release of information may not be re-released to any other person or organization without my written consent.**

Signature of Patient: _____ Date: _____

Signature of Legal Representative and Relationship to Patient: _____ Date: _____