UNIVERSITY OF KENTUCKY, CHANDLER MEDICAL CENTER
LEXINGTON, KENTUCKY

Medical Record Number: ____________________
Department Use Only

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION AND IMAGES

YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAY BE RETURNED TO YOU TO BE COMPLETED

1.) Identity: Patient Name: ____________________ [redacted] ____________________

Address: ____________________ Date of Birth: ____________________

____________________ Phone number: ____________________

2.) Sender and Receiver:
I authorize disclosure of medical information (as indicated):

From:
(Facility to Disclose Records - See back) ____________________

Disclose To: UK Public Relations, UK HealthCare
Marketing, General news media,

3.) Timeframe: I would like records from the following dates: _ through present.

4.) What to disclose: Please check the records you would like disclosed from which facility/location:

HOSPITAL

- ☐ Records related to (specify): ____________________
- ☐ Discharge summary
- ☐ X-Ray Report(s)
- ☐ X-Ray Film(s)
- ☐ ER Notes
- ☒ Other: (specify) ____________________
- ☐ Operative Report(s)
- ☐ Pathology Report(s)
- ☐ Laboratory Report(s)
- ☒ Photo/Video/Other

FACILITY/LOCATION (Indicate from choices on back):
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- ☐ Records related to (specify): ____________________
- ☐ Out patient notes
- ☐ Laboratory Report(s)
- ☐ OB/GYN Notes/Reports
- ☐ TB screening
- ☐ X-Ray Report(s)
- ☐ X-Ray Film(s)
- ☐ Psychological test report
- ☒ Other: (specify) ____________________
- ☐ Pathology Report(s)
- ☐ Immunization Record
- ☒ Photo/Video/Other

5.) Type of Disclosure: ☐ Onsite Review ☐ Paper Copies (☐ Delivered by Mail ☐ Picked up by Receiver)
Media interviews and photo/video filming

6.) Disclosure of special protected records: I authorize the disclosure of information pertaining to:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) ☐ YES ☒ NO/NA
b. The diagnosis or treatment of drug and/or alcohol abuse ☐ YES ☒ NO/NA
c. Treatment and/or consultation for mental health or psychiatric disorders ☐ YES ☒ NO/NA

7.) Purpose of Use/Disclosure: Please indicate/describe each authorized purpose of the use or disclosure:

☐ Request of individual ☐ Marketing (Identify/describe entity/program to be marketed) ____________________
☒ Public Relations/ News/Media ☐ Other (specify) ____________________.

8.) Expiration date: This authorization will expire in 90 days or January 28, 2030, which ever occurs last.

I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective *except* to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
I further understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

____________________ Date

____________________ Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:
☐ Minor ☐ Incompetent ☐ Deceased

____________________ Signature of Legal Representative and Relationship to Patient

____________________ Signature of Witness for Psychiatric Records

TO PATIENTS OR LEGAL DESIGNEES:

FACTS ABOUT OBTAINING YOUR MEDICAL RECORDS:

You have the right to obtain a copy of your medical records. The law requires a **signed authorization form** which contains certain criteria included on this form. This form must be **fully completed** before any medical information can be disclosed. Incomplete forms may be returned for completion.

COSTS:

Kentucky law allows you **one free copy** of your medical record. This free copy is one requested by you for yourself or for a third party. Additional requests will cost **$1.00 per page. It is advised you keep a personal copy of any medical information you request to avoid future costs of obtaining copies.**

WHEN AND HOW WILL I GET MY RECORDS?

The request will be completed within **30 days** of receipt. You will be notified via mail if the records cannot be processed in 30 days. If you would like to pick up your records, indicate this on the form with a phone number where you can be contacted. Otherwise, records will be mailed to the address listed on the authorization.

WHERE TO SUBMIT YOUR REQUEST:

Health care services are provided at many different locations and facilities at the University. Each location is responsible for maintaining and disclosing its own medical records. **Please be specific as to which records you want.** Address your request to the location your care was received. Sending this authorization to the appropriate area listed below will facilitate our response to you.