**Ballard Wright, M.D., PSC (Physician's Practice)**
**2416 Regency Road**
**Lexington, KY 40503**

**Phone (859) 278-1316** **Fax (859) 260-2470**

## Authorization For Use and Disclosure of Protected Health Information

(Form must be filled out in its entirety or it will be returned.)

Patient Name:_____SS#:_____DOB: _____

Address:_____Phone #:_____

**COMPLETE THIS PORTION WHEN REQUESTING OUR RECORDS**:

The undersigned hereby authorizes Ballard Wright, M.D., PSC to disclose medical information to _____ at _____.
(Requestor) (Address) Must have City/State

**COMPLETE THIS PORTION WHEN REQUESTING ANOTHER PROVIDER'S RECORDS BE SENT TO US:**

The undersigned hereby authorizes _____ to disclose medical information to Ballard Wright, M.D., PSC Address w/City & State

**Information requested:**

[ ] Complete Medical Record
[ ] Office Visits
[ ] Labs*
[ ] Imaging Reports
[ ] Medication Record
[ ] Physical Therapy Notes
[ ] Behavioral Medicine Reports*
[ ] Other _____

**Time Period:** From _____ to _____

*[ ] I understand that the information released may contain information relating to alcohol and/or drug abuse, drug tests and/or lab results, psychiatric diagnoses and/or mental health information, communicable diseases including HIV and other sexually transmitted diseases. (Must be checked in order to receive this type of information.)

**How Disclosed:** [ ] On-site review [ ] Paper Copies - [ ] Patient will pick up [ ] Mail to above address
[ ] Fax to _____ (healthcare providers only)

**Purpose of this disclosure:**

[ ] Request of Individual [ ] Other _____

**I understand that this authorization expires:**

[ ] In six (6) months from the date on this form. [ ] Upon the happening of the following event:
(i.e. upon settlement of workers' comp case, etc.)
_____

By signing this form, I understand that my records will be provided to me within thirty (30) days of the receipt of this request. I also understand that I have the authority to revoke this form at any time by written request to be given to/mailed to Stephanie Lewis, Director of Medical Records for Ballard Wright, M.D., PSC at the address listed above. I understand, however, that the revocation of this authorization will not have any effect on actions taken by Ballard Wright, MD, PSC prior to the revocation of this authorization and in reliance of this authorization. I also understand that the information disclosed may be subject to disclosure by the person(s) I have authorized to receive it and that the information no longer is protected by federal privacy regulations. Lastly, I understand that Ballard Wright, M.D., PSC may not condition my treatment on whether or not I sign this authorization.

_____ _____ _____
Signature of Patient/Guardian Date Guardian's Name & Relationship (if applicable)

_____ _____
Witness' Signature Date

**REVERSE SIDE MUST BE COMPLETED IF REQUESTING PROCEDURE NOTES FROM SURGERY CENTER.**
**01/16**