LEWIS COUNTY PRIMARY CARE CENTER, INC.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO LEWIS COUNTY PRIMARY CARE CENTER, INC. dba/ PrimaryPlus

I hereby authorize (Indicate name facility/organization/person) _____ at

(Address of organization) _____ to

release my protected health information as instructed below.

Patient Name: _____ SS#: _____ Date of Birth: _____

To assist us in easily matching your information to our chart
please verify that the patient's name and date of birth are recorded on all documents you send.

Please send the medical records to Lewis County Primary Care Center, Inc. via the following method:

Mail: ATTN: Medical Records c/o Lewis County Primary Care Center, Inc. PO Box 550, Vanceburg, KY 41179.

OR FAX: To the attention of: Medical Records Fax number (including area code) _____

Description of Record(s) to be Released to Lewis County Primary Care Center, Inc. dba/ PrimaryPlus, Vanceburg, KY
Check all that apply & specify dates:

- ○ Clinic Records **(please specify exact location and dates)** including psychiatric, drug, alcohol, and/or HIV/AIDS information _____
- ○ Other Outpatient records(s) including psychiatric, assessment & counseling, drug & alcohol, and/or HIV/AIDS information _____
- ○ Other Information including psychiatric, drug, alcohol, and/or HIV/AIDS information **(please be specific)** _____

_____

- ○ Immunizations _____
- ○ EKG & X-ray reports _____

Specify Date(s) _____

_____

The purpose of the authorized use or disclosure of the information described above is as follows:

_____Medical Evaluation/Treatment ____Transfer of Records to New Treatment Provider ____Insurance Review or Dispute
_____Attorney Review ____School Examination ____Personal Use
_____Other (be specific) _____

Other Information: _____

1. As described in the Notice of Privacy Practices of LCPCC, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by LCPCC in reliance on this authorization, by sending a written revocation to Lewis County Primary Care Center, Inc. Medical Records Department PO Box 550, Vanceburg, KY 41179.

2. I understand that I am not required to sign this authorization form and that LCPCC will not condition the provision of treatment or payment to me on the signing of this form.

3. I understand that if the person or entity that receives the above information is not a health care provider covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

4. This authorization will automatically expire in 60 days if no expiration option is checked below:
   *Expire immediately upon receipt of information by _____
   *Other (insert applicable date or specific event) _____

Signature of Patient/Parent/Legal Guardian (include relationship to patient) _____ Date _____

Full Address _____

Home Phone Number _____

Name of Lewis County Primary Care Center, Inc. representative _____ Date _____