BLUEGRASS RENAL CARE, PSC
MEDICAL RECORD REQUEST

Patient Name: **Birth Date:** **Social Security No.:**

CHECK ONE:

☐ **I HEREBY AUTHORIZE PROVIDER TO USE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT**

☐ **I HEREBY AUTHORIZE_____TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO:** _____

ADDRESS: _____

PHONE NUMBER:_____**FAX NUMBER:**_____

Name(s) of person(s)/organization(s) or class(es) of persons/organizations to which disclosure is to be made:

For treatment date(s):_____

Specify date(s) – this line MUST BE completed

For the following purpose(s):_____Expiration Date:_____

If the request is initiated by the patient (or patient representative), insert "at the request of patient;" otherwise, describe purpose of use or disclosure. If the purpose relates to marketing, indicate whether Provider will receive remuneration.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED

(Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider unless the records were prepared on behalf of Provider)

☐ Patient Demographic Information
☐ Emergency Room Records
☐ Admission History & Physical
☐ Consultation Reports
☐ Operative/Procedure Reports
☐ Lab Test Results
☐ Imaging/Radiology Reports
☐ Cardiac Studies
☐ Physician Progress Notes
☐ Physician Orders
☐ Discharge Summary
☐ Nursing Notes
☐ Billing Records
☐ Entire Record (will not include Billing or records not prepared by or on behalf of Provider unless those items also are selected).
☐ Records not prepared by or on behalf of provider. Provider cannot be responsible for the completeness or accuracy of such records.
☐ Other_____

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program_____; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition_____; information relating to HIV testing, HIV status, or AIDS _____; psychotherapy notes_____. I understand that such information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. statute 65-5601 et seq., and K.S. A. statute 65-6001 et seq**. By my initials, I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization.**

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it by mailing or hand-delivering written notification to the following person:BlueGrass Renal Care, PSC, Office Manager, 3229 Summit Square Place, Suit 240, Lexington, KY 40509.

_____ _____
Date **Signature of Patient/Patient Representative**

_____ _____
Printed Name of Patient Representative **Description of Personal Representative's Authority**

_____ _____
Date **Signature of Witness**

04/22/2014