BLUEGRASS ORTHOPAEDICS

Authorization for Release of Information

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3480 Yorkshire Medical Park
Lexington, Kentucky 40509
(859)263-5140
(859)263-5141 FAX

Toll Free 1(888)422-3170
www.bluegrassortho.com

Account Number: _____
Patient Name: _____
Date of Birth:_____
Social Security Number:_____

I hereby authorize:_____

Address: _____
_____
_____

_____

Phone:(____)_____
Fax: (____)_____

To disclose my health information as described below to:
Bluegrass Orthopaedics
3480 Yorkshire Medical Park
Lexington, KY 40509
Phone (859)263-5140
Fax (859)263-5141

Information to be released:
____Physician Progress Notes
____Work Status
____Radiology Report
____Completed Chart

I am requesting additional information to be released **(this information will not be disclosed unless indicated):**
____Patient Billing
____Radiology Films

_____ _____
Date **Signature of Patient or Guardian**

_____
Witness

If patient is unable to sign, please indicate reason below
____Deceased (must have administrative documentation)
____Minor (emancipated minor may sign for self)
____Incapacitated

Release of medical information provided to our physicians from other healthcare facilities and providers is prohibited by Federal Law. To obtain information from other providers and facilities, you must contact that facility or physician directly.

This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part2). The Federal rules prohibit you from making any further discloser of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.