Cumberland Family Medical Center, Inc.
Health Information Department
P.O. Box 2399 | Russell Springs, KY 42642
P: (270) 858-6655, Opt. 5 | F: (844) 475-2310
medicalrecords@cfmcky.com

Authorization to Disclose Protected Health Information

Patient Name: _____ DOB: _____ SSN: _____

Send Information To: *Please list the name and contact information of the person or entity who will receive the records.*	**Send Information From:** *Please list the provider/location name and contact information of where the patient received care.*

Delivery Method:

*Please include the fax number, email, or mailing address where records should be sent in the **"Send Information"** section above.*

_____ Fax **_____ Secure Email** **_____ Mail** *(Paper [≤ 70 pgs] or CD)* **_____ In-Person Pick-Up** – *Specify Center Location:* _____

Delivery Timeline:

Expedited: **_____ Within 5 Days** or **_____ Same-Day** *(Specify need for expedited requests: _____)*

Standard: **_____ Within 30 Days** or **_____ Authorization for Retention Only – Do Not Send Records**

Records Requested:

I would like the following records (check all that apply):

_____ Last Two Visit Notes Only
_____ Progress Notes
_____ Radiology Reports
_____ Lab Results
_____ Immunization Record
_____ Dental Records and X-Rays
_____ Billing Statement
_____ Other: _____

Sharing of Special Protected Records:
I authorize the release of information related to the following:

1. Testing, diagnosis, and treatment of AIDS, including HIV test results.
   _____ YES **_____ NO**
2. Testing, diagnosis, and treatment of sexually-transmitted diseases (STDs).
   _____ YES **_____ NO**
3. Diagnosis or treatment of drug, alcohol, or other substance abuse.
   _____ YES **_____ NO**
4. Treatment and/or consultation for mental health or psychiatric conditions.
   _____ YES **_____ NO**

I would like records for the following dates: _____ through _____
If no date range is specified, records from the past two years will be released. For requests exceeding two years or for the complete record set, please provide a detailed explanation: _____

I am requesting these records for: _____ Another Provider _____ Personal Use _____ Legal Purposes _____ Insurance Purposes
_____ Social Security/Disability Application _____Social Security Card Certification _____ Other: _____

By signing below, I acknowledge, understand, and agree with the following:

- I have the right to revoke this authorization at any time by submitting a written request to the Center's Health Information Department. I understand that revocation will not apply to actions already taken under this authorization.
- My treatment, payment, or eligibility for benefits is not conditioned upon whether I sign this authorization.
- Once disclosed outside the Center, my information may be re-shared by the recipient and may no longer be protected by privacy laws.
- I release the Center, its employees, officers, and agents from any legal responsibility or liability for the disclosure of information as permitted by this authorization.

I certify that I am the patient or am legally authorized to act on behalf of the patient. I have read and understand the above terms and authorize the use or disclosure of protected health information as specified in this form.

Signature of Patient/Legal Representative: _____ Date: _____

Printed Name: _____ Contact Number: _____

This authorization expires on: _____ *(If no expiration date provided, authorization will expire 90 days from date of signature.*