

Identify the facility where the patient was treated (X):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Jewish Hospital | <input type="checkbox"/> JH Shelbyville | <input type="checkbox"/> Frazier Rehab Institute | <input type="checkbox"/> JH Glenmary Diagnostic |
| <input type="checkbox"/> JH Medical Center East | <input type="checkbox"/> VNA Nazareth Home Care | <input type="checkbox"/> Frazier Rehab Outpatient | <input type="checkbox"/> Our Lady of Peace |
| <input type="checkbox"/> JH Medical Center South | <input type="checkbox"/> Sts. Mary & Elizabeth | <input type="checkbox"/> JH Meade Co. | <input type="checkbox"/> JH Medical Center Southwest |
| <input type="checkbox"/> Employed Physicians | | | |

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD.

Full Name of Patient: _____

Patient Address: _____ City/State _____ Zip Code _____

Patient's Date of Birth: _____ Social Security # _____

INFORMATION TO BE RELEASED:

This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV or AIDS related conditions.

Date of service or date ranges requested _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Neuropsychological reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Psychological reports |
| <input type="checkbox"/> Facesheet | <input type="checkbox"/> Immunization/shot records | <input type="checkbox"/> X-Rays/Medical Imaging Report |
| <input type="checkbox"/> Emergency Department Record | <input type="checkbox"/> Outpatient Records | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Operative reports | <input type="checkbox"/> Itemized bill | <input type="checkbox"/> Entire medical record |

THE ABOVE INFORMATION IS TO BE RELEASED TO:

Name & Title: _____

Agency/Hosp: _____

Street Address: _____

City/State/Zip: _____ Phone Number: _____

THE ABOVE INFORMATION IS REQUESTED TO BE RELEASED FOR THE FOLLOWING PURPOSE (X):

- | | | |
|---|---|--|
| <input type="checkbox"/> Continued medical care | <input type="checkbox"/> Legal claim processing | <input type="checkbox"/> External quality/utilization review |
| <input type="checkbox"/> Personal interest | <input type="checkbox"/> Insurance claim processing | <input type="checkbox"/> Other (specify) _____ |

This authorization must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. Revocation must be made in writing. This authorization will expire on _____.

I hereby state that I have read and fully understand the above statements as they apply to me. I acknowledge that I understand treatment, payment, enrollment in any health plan, or eligibility for medical records to the purpose and extent stated above. Once these records are released, the information is not protected by Jewish Hospital & St. Mary's HealthCare, Inc. (JHSMH) and may potentially be redisclosed by the party who received these records. I release JHSMH, its employees, agents, directors, officers, and affiliates, from any liability that may be incurred by giving this information to the above - named person or agency.

The undersigned acknowledges that the provision of free medical records by any health care provider who receives this release shall fulfill that health care provider's obligation to provide one (1) free copy of the medical records, and that any future request for medical records from the health care provider may result in a copying fee up to one dollar (\$1) per page.

Patient Signature

Date

Patient Guardian, Authorized Representative

Witness

Relationship to Patient on chart

- Proof or guardianship received or on chart
- ID checked by _____
- Released by _____
- First free copy Yes No

Consent Forms



JEWISH HOSPITAL & ST. MARY'S HEALTHCARE
GUIDE TO OBTAINING MEDICAL RECORDS

As a patient you are entitled to one free copy of your medical record under Kentucky Law (KRS 422.317). Please follow the steps below to obtain copies of your medical records:

1. Contact a Release of Information associate between the hours of 9am and 5pm, Monday through Friday, at **(502) 361-6623** to request an authorization form. This form is also available on the JHSMH website for your convenience. To access this form log on to www.jhsmh.org, select the Patients & Visitors option at the top of the screen, go to the Notice of Privacy Practices option, and print the "Medical Records Request" form listed under "Forms & Additional Information".
2. To obtain medical records for any of the following facilities:
Jewish Hospital, Jewish Hospital Medical Center East, Jewish Hospital Medical Center South, Jewish Hospital Shelbyville, Jewish Hospital Medical Center Southwest, Jewish Hospital Glenmary Diagnostic, Sts. Mary & Elizabeth Hospital.

Please mail the completed authorization form and copy of your ID to the Health Information Management Dept:

Attn: Release of Information
1850 Bluegrass Ave
Louisville, KY 40215

3. To obtain medical records from the following facilities , please mail your request to the address specified below.

Our Lady of Peace 2020 Newburg Road Louisville, KY 40205 Phone: (502) 479-4510	VNA Nazareth Home Care 101 W. Chestnut Street Louisville, KY 40202 Phone: (502) 584-2456
Jewish Hospital of Meade County 534 Fairway Drive Bradenburg, KY 40108 Phone: (270) 422-5000	The Physician Group 6801 Dixie Hwy Ste# 113E Louisville, KY 40258 Phone: (502) 479-1400

4. For your convenience, the copy will be mailed to you or the designated party.

If you need films from Radiology procedures you will need to contact the appropriate Radiology Department or Diagnostic Center.

***NOTE: If the patient is under age eighteen (18) and not emancipated in accordance with Kentucky law, a parent/legal guardian must sign the authorization form. If the patient is mentally incapacitated, the patient's legal representative must sign the authorization form as outlined in the following order under KRS 311.631 (1a-f): Judicially appointed guardian, durable health care power of attorney, spouse, adult child or majority of adult children; parents or nearest relative. Proof of legal representation must be supplied to the hospital. If the patient is physically unable to sign, another individual may sign at the patient's discretion if witnessed by a third party. If the patient is deceased, the form must be signed by the administrator or executor of the decedent's estate pursuant to 45 CFR 164.502(g)(1)(4). If there is no estate and no administrator or executor, and the next of kin is requesting medical records for death benefits or insurance proceeds, JHSMH will release information directly to the company administering the benefits upon receipt of the appropriate documentation. Power of Attorney does not apply in event of a death.*