

I understand that this authorization covers only treatment prior to the date below.

Commonwealth Health Corporation and its subsidiaries are hereby released from any liability and the undersigned will hold Commonwealth Health Corporation harmless for complying with this authorization. A photostat copy of this authorization is acceptable and will be treated as original.

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

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Revocation date _____ Patient/Legal Representative: _____

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information comes with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

Patient/Legal Representative Signature: _____ Date: _____

Relationship to patient: _____

Please mail the completed authorization form to:

Attn: Medical Records
Health Information Management Department
The Medical Center
250 Park Street
Bowling Green, KY 42101

Fax form to 270-745-1272

Email Form to: requestrecords@mchealth.net

FOR OFFICE USE ONLY

Released by: _____ Date: _____

How were records released: In-person Mail Email Fax

of pages copied: _____ First free copy: Yes No