Authorization for Release of Protected Health Information to Patient

My signature below authorizes **White House Clinics** to **disclose** to me the following protected health information (PHI):

_____All Records Pertinent to Continuing Primary Care
_____Records Regarding Treatment of Specific Illness, Condition, or Injury
(please specify _____)
_____Records Covering Period of Time from _____ to _____
_____Other (please specify_____)

My indication above acknowledges that I understand that this authorization may include the use or disclosure of information concerning HIV testing, treatment of HIV/AIDS and related conditions, diagnosis and treatment of drug and/or alcohol abuse, and psychiatric/psychological conditions to/from the organizations listed above.

The purpose of this disclosure is:

_____Future Medical Care
_____Legal Claim Processing
_____Insurance Claim Processing
_____Other (please specify _____)

I wish to have the requested medical records given to me in the following form (please choose one):

_____Paper (within 10 business days)
_____CD (within 3 business days)

I understand that I have the right to change or cancel this authorization at any time by notifying the Privacy Officer, in writing, at Health Help, Inc., Attention: Privacy Officer, 401 Highland Park Dr., Richmond, Kentucky 40475. I also understand that the changes or cancellation will not affect action taken based on this authorization prior to the change or cancellation.

I understand that I do not have to sign this authorization and that White House Clinic cannot condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed based on this authorization may be subject to redisclosure by the recipient named above and may not be protected by federal laws and regulations regarding the privacy of my protected health information. I understand that I have the right to inspect and copy the information to be disclosed.

I understand that White House Clinic may receive reimbursement from the above recipient for the expense of supplies and labor necessary to disclose my personal health information.

This authorization expires on _____ (list specific day or event). I certify that I have received a copy of this authorization (if I so choose).

_____	_____
Patient Name	Patient Date of Birth
_____	_____
Signature of Patient/Legal Guardian	Relationship to Patient (if other than self)
_____	_____
Signature of Witness	Date

McKee	Berea	Berea Primary Care	Richmond	Irvine	Mt. Vernon	Paint Lick
1010 Main St South	104 Legacy Dr.	305 Estill Street	401 Highland Park Dr.	30 Stacy Lane Rd	116 Progress Drive	11652 Highway 52 E
McKee, KY 40447	Berea, KY 40403	Berea, KY 40403	Richmond, KY 40475	Irvine, KY 40336	Mt. Vernon, KY 40456	Paint Lick, KY 40461
P: (606) 287-7104	P: (859) 986-2323	P: (859) 985-1415	P: (859) 626-7700	P: (606) 723-0665	P: (606) 256-2143	P: (859) 925-2444
F: (606) 287-4409	F: (859) 986-7728	F: (859) 985-6752	F: (859) 626-7703	F: (606) 723-0680	F: (606) 256-9762	F: (859) 925-2334