LEWIS COUNTY PRIMARY CARE CENTER, INC.
P.O. BOX 550
VANCEBURG, KY 41179

Authorization to Release Protected Health Information

Name ____ DOB ___________________________

Date of Request ____________________ Social Security Number ___________________________

By signing this authorization, I authorize Lewis County Primary Care Center, Inc. to use and/or disclose certain protected health information (PHI) about me to

____
Name of entity to receive this information

This authorization permits Lewis County Primary Care Center Inc. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) or services, level of detail to be released, origin of information, etc):

____

____

The information will be used or disclosed for the following purpose:

____

____
Describe each purpose for which you are authorizing the use or disclosure.

This authorization will expire on: ____
Expiration date or defined event

I do not have to sign this authorization in order to receive treatment from Lewis County Primary Care Center, Inc. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Lewis County Primary Care Center, Inc., PO Box 550, Vanceburg, KY 41179.

Signature of Patient/Guardian/Representative ________________________________ Relationship __________

Printed Name of Patient /Guardian/Representative ____________________________ Date ___/_____/_____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE PROVIDED TO THE PATIENT