## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Alexius M. Bishop, M.D.
Douglas P. Poon, M.D.
Kelley Burchell-Young, M.D.

Elizabeth Combs, APRN, CPNP
Lynn Huesman, APRN, FNP-C

Patient:_____ Date of Birth:_____ Date:_____

Address:_____
Street Address City State Zip Code Telephone

X_____ _____ _____
Signature of Patient or Patient's Representative Relationship to Patient Expiration Date or 30 days

X_____, Signature of Witness

**MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED**

I hereby authorize the use and disclosure (release) of my medical record information:

**From: Alexius M. Bishop, MD PSC**
**45 Cavalier Blvd., Florence, KY 41042**
**859-371-7400 ** Fax: 859-371-8472**

To:_____
_____
_____

The information to be released includes: _____Entire Medical Record _____ Other_____

The Medical Record Information will be used and/or disclosed for the following purposes:
_____ At the request of the individual _____Changing Primary Care Physicians _____Changing/Seeing Specialist
Other:_____

I acknowledge and agree that the term Medical Record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

**Please exclude the following information, if it is part of my Medical Record Information**
(Check any or all you want excluded from this authorization for use or disclosure)

_____Chemical Dependence/Substance Abuse _____Psychiatric/Psychological Conditions _____Sexually Transmitted Disease
_____ Alcohol _____Drugs

I understand this Authorization shall remain in effect for a period of 30 days. I further understand I may revoke this Authorization at any time by notifying ALEXIUS M. BISHOP, MD PSC in writing. However, if I choose to do so, I understand my revocation will not affect any actions taken by ALEXIUS M. BISHOP, MD PSC before receiving my revocation.

I understand I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request to ALEXIUS M. BISHOP, MD PSC Privacy Officer. I also understand I have the option to "opt-out" of receiving communication from my provider should I choose to do so as long as I provide them with the request in writing.

I am designating _____, who is at least 18 years of age and who may be required to show photo I.D. to pick up my medical records.

Patient received "one free" copy by:_____ Date:_____

Refusal to sign this authorization in no way affects my treatment, payment or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. Updated 01/17/2022