



GENERAL REQUEST FOR RELEASE OF MEDICAL RECORDS

To be used for release of information to the patient, their legal representative, or to a provider of their choice; or to request records from another provider.

In order to release your/the patient's records, you must sign a request for release. This form must be complete with the patient's name, the last 4 digits of the patient's social security number, and the patient's date of birth. It is your responsibility to read this form in full and to ask any questions before the record is released. No phone call requests will be honored.

Designate Who You Want to Release Your Records

University of Louisville Physicians, Inc. (UofL Physicians) Release Your Records

The following information explains our policy for releasing protected health information:

- Medical records will be released only to the patient or the patient's authorized representative. Law office/attorney medical records requests must have valid authorization with request.
- Please be prepared to show ID when picking up records in person. This is for the protection of your personal health information.
- Patient's legal representatives must provide appropriate documentation to demonstrate their legal status.
- HIV, STD, substance abuse, and psychiatric records are not released without specific separate authorization.
- Please allow up to 30 days for records stored off site; however, UofL Physicians may take up to 60 days to process the request, if necessary.
- First copy provided free of charge.

Release Records to (provide information below): Patient/Legal Representative Provider Office

Name _____ Phone _____

Address _____
Street City State Zip

Another Provider Release Your Records to UofL Physicians

Provider Name _____ Phone _____

Provider Address _____
Street City State Zip

Patient Information, Signature, and Records Being Released

Patient's Name (Please Print) Date of Birth Last 4 Digits of SSN

Patient/Parent/Legal Guardian Signature Witness Signature Date

If Parent/Legal Guardian, Print Name _____

Records Being Released : Date Range From _____ To _____

Entire Chart Labs Office Notes Other (Specify Below)

Do Not Write Below This Line – For Office Use Only

UofL Physicians Practice Site (optional) _____

Phone _____ Fax _____