

Highlands Family Medicine

A Home for your Health in the Highlands

1250 Bardstown Road, Louisville, Kentucky 40204 502/456-7047

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: _____

Other names used: _____

Date of Birth: _____ *Social Security #:* _____

I hereby consent to the release of all medical information related to the treatment of the above named patient from the following (physicians, hospitals, labs, etc.):

Specific Information to be Released:

“Diagnosis, prognosis, plan of treatment and demographic information.”

Other: _____

Covering Treatment from _____ *to Present*

Released to: Dr. Roszell, Highlands Family Medicine
1250 Bardstown Road, Louisville, KY 40204
502-456-7047 office 502-456-7048 fax

Released for Stated Purpose ONLY: (Any other use is forbidden)

“Diagnosis and Treatment”

Other: _____

**THIS CONSENT WILL CONTINUE IN FORCE AND EFFECT
UNTIL REVOKED BY ME IN WRITING.**

Date: _____ *Signed:* _____
Patient, or Party Authorized to Consent (please note relationship)

This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal Regulation (42 CFR Part 2).