Jackson Purchase Medical Associates, P.S.C.

225 Medical Center Drive, Suite 201
P. O. Box 7448
Paducah, KY 42002-7448
(270) 441-4200 Fax (270) 441-4249

RELEASE OF RECORDS

A patient may receive one free copy of their records. Any additional paper copies will be at a charge of $1.00 per page or an electronic copy of your records can be provided at a cost of $25.00.

Records requested by an attorney's office, insurance company, etc., will be billed to the requesting attorney or company.

There is no charge for records that are being sent to another physician.

Record releases are done in the order they are received. The usual turnaround time is 7-10 days after payment has been received, but could be longer.

If the records are needed by a certain date, please specify this on the Release of Information form and all efforts will be made to have the records ready to be picked up by that date.

Only records produced by this organization will be copied. Records produced in other healthcare facilities will not be released. If you bring records from another physician(s) office to be placed in your Jackson Purchase Medical Associates chart, they will not be released unless you specifically request us to do so. (Please make copies of them prior to giving them to us).

Records will not be released to anyone other than the patient unless specified on the release. If you are Power of Attorney or Executrix of Estate of the patient, documentation must be presented to verify status and a copy will be placed in the chart for future reference.

Thank You,

Medical Records Department

Jackson Purchase Medical Associates, PSC

P.O. Box 7448, Paducah, KY 42002-7448
Phone: 270-441-4200 Fax 270-441-4249

d.b.a.

Ballard County Medical Clinic
Internal Medicine Group
Paducah Endocrinology
Paducah Family Medicine
Paducah Rheumatology
RediCare
Western Kentucky Kidney Specialists

Medical Records Release

I hereby authorize the use or disclosure of my health information as described below, including any personal or confidential information of a sensitive nature, psychological or psychiatric records, and substance abuse, including drugs or alcohol treatment or information pertaining to communicable diseases, including HIV status, hepatitis or venereal diseases. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. A photostatic/electronic copy shall be as valid as the original authorization. This information should not be disclosed to any other person or company without further authorization. Other physicians' or outside facilities' records should be requested from their office.

Patient's Name : _____ DOB: _____

Phone No.:_____ Social Security Number: _____

Address: _____

_____

Description of information to be released: _____

_____

The purpose or need for this disclosure is: _____

_____

Records released from:	Records to be released to:
Facility Name _____	Facility Name _____
Address _____	Address _____
Phone & Fax # _____	Phone & Fax # _____

I understand that I may revoke this authorization at any time by sending a written notice to Jackson Purchase Medical Associates, PSC. I understand that any release which has been made prior to such revocation that was made in reliance upon this authorization shall not constitute a breach of any rights to confidentiality.

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorize the health care provider to release the information specified to the organization, agency or individual named on this request with the ***EXCEPTION*** of:

_____Substance abuse Initials _____AIDS/HIV Initials _____Psychological/Psychiatric conditions Initials

_____ Records relating to any treatment that I paid out of pocket in full.
Initials

☐ **I request that my medical records be in electronic format**

Signature:_____ Date: _____

Relationship to patient if a minor or deceased: _____

This authorization will automatically expire in one year.