Paintsville Internal Medicine

Loey Kousa, MD   Kitta Kousa, MD

Authorization for Release of Patient Information

Patient Name: Date of Birth:

Date:

I hereby authorize:

Telephone Number:

To disclose the above named individual's health information as described below:

☐ Entire Medical Record

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I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization:

FAX REPORTS TO: 606-789-6202 AND, OR mail to: Paintsville Internal Medicine.
Loey J Kousa MD / Kitta Kousa MD, PO Box 1271, Paintsville, KY 41240. Tel: (606) 789-6086.

Description of the purpose of the use and/or disclosure: ☐ Continuing Care

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I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until ______________________________ (date or event).

I understand I may revoke this authorization at any time by notifying The Primary Care Clinic. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

______________________________   ______________________________
Signature of Patient or Patient's Representative   Date

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Printed name of Patient or Patient's Representative

______________________________   ______________________________
Relationship to Patient   or   Legal Authority (attach supporting documentation