Jackson Purchase Medical Center
Health Information Management
1099 Medical Center Circle, Mayfield, KY 42066
Ph.270-251-4142 option 3 fax. 270-251-4144

**This request is for hospital medical records only. If you need your Dr.'s office records you will need to go to their office. If you do not fill out the highlighted areas your request can't be completed and may require another trip here to complete. We can't accept information over the phone.
*All requests will be received and process within 3 business days of request unless further information is needed. Drop off at HIM, 4th floor MOB, fax to 270-251-4144, or mail to address above.

Name:_____
Phone Number:_(____)_____-_____ if there is any questions we will call this number to discuss with you.

Choose one of the below to receive your records:
____I would like to have my records mailed to me. Please fill out address box on Page 2.
____I would like my records faxed to myself/doctor/attorney/ins co./etc. please fill out the fax/mail box on page 2.
____I would like my records emailed to the email address on page 2. (This will be an encrypted email)

Please check below if it is ok to put your records on a CD if there is a high count of pages. If this is the case you can't receive records by fax or email.
____I would like my records put on a CD.

If you have any other medical records questions please check this box and we will be glad to call you as soon as your request is received. ☐

Jackson Purchase Medical Center
RELEASE OF INFORMATION
AUTHORIZATION / REQUISITION FORM

Section A: *This section to be completed by the patient.*

Patient Full Name:		Phone Number:	( ) -
Address:		Date of Birth:	

Fax/Mail	Attn:	
	Phone#:	
	Fax#:	
	Address:	

Email _____@_____(only fill this out if you want records emailed)

Date(s) of Service: Month/day/year _____ or range _____ to _____

List specific description of information to be released:

☐ Anesthesia Record	☐ Discharge Summary	☐ X-ray Reports	☐ Physician Orders	☐ All Records
☐ Billing Records	☐ EKG's	☐ Laboratory	☐ PT/OT/Speech Record	☐ Other _____
☐ UB04	☐ Emergency Records	☐ Medication Records	☐ Pathology Report	☐ _____
☐ Itemized Bills	☐ Demographics	☐ Nursing Records	☐ Progress Notes	☐ _____
☐ Consultation	☐ History & Physical	☐ Surgery/Proc Record	☐ Acctg of Disclosure	☐ _____

Do you want the Hospital to release your Psychotherapy notes (if any) to the person or facility you have listed above?
(Circle One) YES NO _____(initial here)

Describe the purpose /reason for this request:

Section B: *Must be completed by the patient for all authorizations:*

The patient or the patient's representative must read/acknowledge the following statements:

1. I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on _____/ _____ / _____. ***(If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)***
3. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
4. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
5. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
6. I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
7. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.
8. _____I understand if it is a large amount of documents that it will be put on a CD that is Not password protected.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

(Signature of Patient or Patient's representative) X_____	(Date) _____

(If patient representative, please print name below and provide proof/documentation the representative has which provides the authority to act for the patient.)

FOR OFFICE USE ONLY:

Verified :	Yes No		
By:		MR#	
Signature:	Yes No	Acct#	

ROI