



**AUTHORIZATION FOR  
RELEASE OF INFORMATION**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

**FROM: PARAGON FAMILY PRACTICE, 1055 WELLINGTON WAY, SUITE 275, LEXINGTON, KY 40513**

**TO: NAME:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**TO: PARAGON FAMILY PRACTICE, 1055 WELLINGTON WAY, SUITE 275, LEXINGTON, KY 40513**

**FROM: NAME:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Information to be released covers the period(s) of hospitalization from \_\_\_\_\_ through \_\_\_\_\_ and/or outpatient treatments on \_\_\_\_\_.

1. Specific description, including dates of information to be disclosed (Please check all that apply):
- Any and all records in the possession of Paragon Family Practice, including mental health, HIV and/or substance abuse records.
  - Records covering the period of time \_\_\_\_\_ to \_\_\_\_\_
  - Other (specify): \_\_\_\_\_
- \_\_\_\_\_
- Any and all records, including mental health, HIV, STD, and/or substance abuse records.

2. Specific purpose of disclosure: \_\_\_\_\_

3. This authorization will expire on: \_\_\_\_\_ (up to one year from date signed)

I understand that I have the right to revoke this authorization in writing, at any time, by sending written notification to the privacy officer at Paragon Family Practice. I also understand that the revocation will not have any effect on any actions that Paragon Family Practice took before receiving the revocation.

I understand that I do not have to sign this authorization, and that Paragon Family Practice may not condition treatment on or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by federal laws and regulations regarding the privacy of my protected health information.

\_\_\_\_\_  
Signature of Patient/ Representative

\_\_\_\_\_  
Description of Personal Representative

\_\_\_\_\_  
Date