SOUTHERN KENTUCKY PRIMARY CARE

DWIGHT H. SUTTON, MD

May Southern Kentucky Primary Care and/or members of the office staff release medical information to specified persons other than you? **YES** ____ **NO** ____

Authorized Person	**Relationship to You**
____________________________	_________________________
____________________________	_________________________
____________________________	_________________________

What information may be released ?

Lab results	**Yes** ____	**No** ____
X-ray reports	**Yes** ____	**No** ____
Medications	**Yes** ____	**No** ____
Appointments	**Yes** ____	**No** ____
Financial / Billing	**Yes** ____	**No** ____

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office which contain my health history, symptoms, examination test results, diagnoses and treatment pans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians and healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises a copy of the “Notice of Privacy Practices for Protected Health Information” which provides a more complete description of the uses and disclosures of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me upon request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

_________________________________   __________________________

Patient Signature   **Date**