LOUISVILLE CONCIERGE MEDICINE, PLLC

4950 Norton Healthcare Blvd, Norton Medical Plaza, Suite 302. Louisville, KY 40241
PH: 502.618.3535 FAX: 502.618.3537

Authorization for Release of Medical Records

DISCLAIMER: NOT FOR USE FOR MARKETING, RESEARCH OR UNDERWRITING PURPOSES

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Social Security No: _____

Requesting Records to be sent from:

_____
_____
_____
_____
_____

Please forward my Records to:

Louisville Concierge Medicine, PLLC
Alexis G.Karageorge, MD
4950 Norton Healthcare Blvd, Suite 302
Louisville, KY 40241
Fax 502.618.3537

Information to be disclosed (choose one):

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition(s): _____
  _____
- ☐ My health information for the following dates: _____
- ☐ My claims and billing information only: _____
- ☐ Other: _____

Purpose of disclosure:

- ☐ At my request
- ☐ Other (specify) _____

This authorization expires 60 days from the date signed unless specified otherwise.

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that if I have been treated for drug or alcohol abuse my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____ _____
Signature Date

If signed by a person other than the patient, please indicate relationship and authority to do so:

- ☐ Legal Guardian
- ☐ Parent of minor child
- ☐ Power of Attorney
- ☐ Personal representative of deceased