**GRAVES-GILBERT CLINIC @ WESTERN KENTUCKY UNIVERSITY**

***AUTHORIZATION TO RELEASE RESTRICTED HEALTH INFORMATION***

| _____ | _____ | _____ |
|---|---|---|
| Patient's name (please type or print) | Social security number | Date of birth |

The undersigned hereby authorizes _____ to disclose, reveal, or open for observation or inspection to Graves-Gilbert Clinic any report, statement, x-ray, analysis, diagnosis, chart or record maintained or kept by the facility named above.

Although this release is not limited in scope please send the following items at this time.

____ All records pertinent to treatment and continuing care
____ Records compiled between the dates of _____ and _____
____ EKG Reports
____ Lab Reports
____ Pap Reports
____ X-ray Reports
____ Immunization Records
____ Notes prepared by Dr. _____
____ Other (please describe) _____
_____

If the individual signing this release is one other than the patient, then the undersigned agrees to indemnify the individual or entity releasing the information from any losses or liability resulting from the release of information.

X_____ _____
Patient Signature/Guardian Signature Date

X_____ _____
Relationship if signed by someone other than patient Date

Mail (please include mailing address) _____

Pick Up _____

Fax (please include Fax number) _____

**PLEASE FORWARD INFORMATION TO:**

Graves-Gilbert Clinic @ WKU
1681 Normal Drive
Bowling Green, KY 42101
(270) 745-2273 phone
(270) 783-3763 fax