



AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip _____ Phone _____
Clinic/Hospital/Health Care Provider: <small>(Who has the information you want released? Please list the specific Hospital and/or clinic.)</small>	Name _____ Address _____ City _____ State _____ Zip _____
Receiving Party: Choose One: <input type="checkbox"/> Me <input type="checkbox"/> Other <small>(Where do you want the information sent? Who may have the information?)</small>	Name _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Fax Number _____
Information to be Released: <small>(What do you want sent or released? Check the appropriate box.)</small>	Date(s) of Service: From ____/____/____ To ____/____/____ <input type="checkbox"/> Physician Office Medical Records <input type="checkbox"/> Billing Records <input type="checkbox"/> Hospital Medical Records <input type="checkbox"/> Copies of Films/Images <u>Only record types checked below:</u> <input type="checkbox"/> Discharge summary/note <input type="checkbox"/> Radiology reports <input type="checkbox"/> Emergency record(s) <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Rehab records (PT/OT/ST) <input type="checkbox"/> Immunization/allergy record <input type="checkbox"/> Operative report <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Pathology reports <input type="checkbox"/> Consultations <input type="checkbox"/> Progress Notes <input type="checkbox"/> Other records (Specify record types(s)) _____
Special Authorization Section <small>(Per IC-16-39-2 this special authorization is valid for 180 days.)</small>	State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate): Alcohol, Drug, or Substance Abuse Records <input type="checkbox"/> Yes <input type="checkbox"/> No HIV Testing and Results <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health Records <input type="checkbox"/> Yes <input type="checkbox"/> No Psychotherapy Records <input type="checkbox"/> Yes <input type="checkbox"/> No Genetic Records <input type="checkbox"/> Yes <input type="checkbox"/> No
Release Instructions: <small>(How and When do you want the information?)</small>	Release Method/Format requested: (check one) <input type="checkbox"/> Electronic Access – E-mail address _____ <input type="checkbox"/> Paper <input type="checkbox"/> CD/DVD <input type="checkbox"/> Fax (patient care only) Date information is needed _____ NOTE: Please allow 30 days for processing
Purpose of Release: <small>(Why is it needed?)</small>	<input type="checkbox"/> Personal use* <input type="checkbox"/> Insurance application* <input type="checkbox"/> Social Security appeal <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance payment/claim <input type="checkbox"/> Social Security Disability Determination* <input type="checkbox"/> Transfer of care <input type="checkbox"/> Litigation/legal* <input type="checkbox"/> Other* _____ <small>*Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524</small>
<ul style="list-style-type: none"> • This authorization will expire in 60 days from the date signed unless otherwise specified _____ • I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization. • I understand that I am not required to sign this Authorization in order to receive health care treatment. • IUH's records may include records that it received from other organizations. If these records have been used by IUH, and filed in the record IUH maintains about you, these records may be released with your IUH records. • IUH cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release IUH from any and all liability resulting from a redisclosure by the recipient. 	
Your signature indicates that you have read and understand this form, and you authorize release of your information as described above. _____ Patient/Legal Guardian Signature Date _____ Authority to act on behalf of patient (Attach documentation)	TO BE COMPLETED BY HOSPITAL STAFF: Initials of person releasing information ____ Date _____ Photo ID/Signature verified (if not currently admitted) _____ Medical Record Number _____ Patient Encounter Number _____

