



**AUTHORIZATION FOR DISCLOSURE OF
PATIENT-IDENTIFIABLE HEALTH INFORMATION**

MEDICAL RECORD NO. _____
PATIENT ACCOUNT NO. _____
 SPOKE WITH _____
 VERIFIED PATIENT SIGNATURE
SIGNATURE _____ DATE _____

Patient Name _____ Birth Date _____ SS# _____
Patient Address _____

1. I authorize the use or disclosure of the health information described below.
2. The following individual or organization is authorized to make the disclosure:

Address _____

3. This information may be disclosed to and used by the following individual or organization:

Address _____

For the purpose of _____

4. The information I authorize disclosed is:

From (date) _____ to (date) _____

- Test results (please specify) _____
- Pertinent parts/abstract of medical records
- History and Physical
- Discharge Summary
- Laboratory Report
- Designated Record Set (medical records, billing, other health care providers)
- Any & All (medical records)
- X-ray and imaging films
- Pathology slides
- Consultation
- Photographs, Videotapes, Digital & other Images

(A separate fee for reproduction of photographs or other visual recording media may be assessed)

Other _____

5. I understand that my health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
6. I understand that I have a right to revoke this authorization at any time and that I must do so in writing to the Health Information Services Department. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information before it is disclosed. I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Director of Health Information Services at (219) 836-4535.
8. I understand there may be a fee for copying these records.
9. I authorize _____ to pick up the requested copies of my health information and understand that he/she must prove their identity with a valid drivers license or state identification card.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness

NOTE: If you have received treatment or healthcare services at Home Health or Physician Network Office, your request to inspect or copy must be directed to that facility.