



Medical Record Number _____

Account Number _____

_____ Spoke with _____

_____ Verified Patient Signature

Signature _____ Date _____

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

Patient Name _____ Birth Date _____ Telephone (____) _____

Patient Address _____ SS # _____

City/State/Zip _____

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

ST. CATHERINE HOSPITAL

Address 4321 FIR STREET EAST CHICAGO, IN 46312

- This Information may be disclosed to and used by the following individual or organization:

Address _____

For the purpose of _____

- The information I authorize disclosed is:

From (date) _____ to (date) _____

- Pertinent parts/abstract of medical records
- History and Physical
- Consultation
- Discharge Summary / Clinical Resume
- Any & All (medical records)
- Photographs, Videotapes, Digital & other Images
- X-ray and Imaging films/Reports
- Laboratory Report
- Nuclear Medicine Report/Film
- Pathology Report and Slides
- Billing: Itemized Statement (800-210-9776)

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

- Designated Record Set (medical records, billing, other health care providers)
- Other _____

- I understand that my health record may include 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.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the Health Information Management 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.
- 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 to be used or disclosed. I understand 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 Management at (219) 392-7171.
- I understand there may be a fee for copying these records.
- I authorize _____ to pick up the requested copies of my record and understand that he/she must be able to prove their identity with a valid drivers license or state identification card.

Signature of Patient or Legal Representative

Date

Signed by Legal Representative, Relationship to Patient

Signature of Witness