

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Patient Address \_\_\_\_\_ SS # \_\_\_\_\_

1. I authorize the use or disclosure of health information described below.

2. The following individual or organization is authorized to make the disclosure:

ST. MARY MEDICAL CENTER

Address 1500 S. LAKE PARK AVENUE; HOBART, IN 46342

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) \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Pertinent parts/abstract of medical records     | <input type="checkbox"/> X-ray Report and Imaging Films             |
| <input type="checkbox"/> History and Physical                            | <input type="checkbox"/> Laboratory Report                          |
| <input type="checkbox"/> Consultation                                    | <input type="checkbox"/> Nuclear Medicine Report and File           |
| <input type="checkbox"/> Discharge Summary / Clinical Resume             | <input type="checkbox"/> Pathology Report and Slides                |
| <input type="checkbox"/> Any & All (medical records)                     | <input type="checkbox"/> Billing: Itemized Statement (800-228-3556) |
| <input type="checkbox"/> Photographs, Videotapes, Digital & other Images |   |

**(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 \_\_\_\_\_

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 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 to be used or 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 219-947-6172.
8. I understand there may be a fee for copying these records.
9. 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

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness

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

**St. Mary Medical Center**

Hobart, IN 46342

Health Information: (219)-947-6160

Health Information Fax: (219) 947-6169

OFFICE USE ONLY

MR # \_\_\_\_\_ ACC # \_\_\_\_\_

\_\_\_ Spoke With \_\_\_\_\_

\_\_\_ Verified Patient Signature

Associate:  
Signature \_\_\_\_\_

Date \_\_\_\_\_

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