Indiana University Health

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Phone _____

Clinic/Hospital/Health Care Provider:

(Who has the information you want released? Please list the specific Hospital and/or clinic.)

Name _____

Address _____

City _____ State _____ Zip _____

Receiving Party:

Choose One:

☐ Me ☐ Other

(Where do you want the information sent? Who may have the information?)

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Information to be Released:

(What do you want sent or released? Check the appropriate box.)

Date(s) of Service: From _____/_____/_____ To _____/_____/_____

☐ Physician Office Medical Records ☐ Billing Records
☐ Hospital Medical Records ☐ Copies of Films/Images

Only record types checked below:

☐ Discharge summary/note ☐ Radiology reports ☐ Emergency record(s)
☐ History & Physical Exam ☐ Rehab records (PT/OT/ST) ☐ Immunization/allergy record
☐ Operative report ☐ Laboratory reports ☐ Pathology reports
☐ Consultations ☐ Progress Notes
☐ Other records (Specify record types(s)) _____

Special Authorization Section

(Per IC-16-39-2 this special authorization is valid for 180 days.)

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	☐ Yes	☐ No
HIV Testing and Results	☐ Yes	☐ No
Mental Health Records	☐ Yes	☐ No
Psychotherapy Records	☐ Yes	☐ No
Genetic Records	☐ Yes	☐ No

Release Instructions:

(How and When do you want the information?)

Release Method/Format requested: (check one)

☐ Electronic Access – E-mail address _____
☐ Paper ☐ CD/DVD ☐ Fax (patient care only)

Date information is needed _____ NOTE: Please allow 30 days for processing

Purpose of Release:

(Why is it needed?)

☐ Personal use* ☐ Insurance application* ☐ Social Security appeal
☐ Continuing Care ☐ Insurance payment/claim ☐ Social Security Disability Determination*
☐ Transfer of care ☐ Litigation/legal* ☐ Other* _____

*Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

- 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 _____