



## Authorization to Release and Disclose Patient Information Form English

<b>PATIENT INFORMATION</b>																						
Name _____ Prior Name(s) _____ Date of Birth _____ Address _____ City _____ State _____ Zip _____ Phone _____																						
<b>Clinic/Hospital/Health Care Provider:</b> Who has the information you want released? Please add the specific IU Health location and/or IU Health healthcare provider. _____																						
<b>Receiving Party:</b> Choose One: <input type="checkbox"/> Me <input type="checkbox"/> Other <b>Only one receiving party allowed per form.</b> Where do you want the information sent? _____																						
<b>Information to be Released:</b> Dates of Service or Date Range is Required. What do you want sent or released? Check the appropriate box(es). _____																						
<b>Date(s) of Service:</b> From _____ / _____ / _____ To _____ / _____ / _____ Only record types checked below (could include medical records such as paper, electronic, digital or verbal communications between IU Health and the receiving party): <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Discharge Summary/Note</td> <td style="width: 33%;"><input type="checkbox"/> Radiology Reports</td> <td style="width: 33%;"><input type="checkbox"/> Emergency Record(s)</td> </tr> <tr> <td><input type="checkbox"/> History &amp; Physical Exam</td> <td><input type="checkbox"/> Copies of Films/Images</td> <td><input type="checkbox"/> Lifeline EMS: Transport Record (Air/Ground)</td> </tr> <tr> <td><input type="checkbox"/> Operative Report</td> <td><input type="checkbox"/> Rehab Records (PT/OT/ST)</td> <td><input type="checkbox"/> Immunization/Allergy Record</td> </tr> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Laboratory Reports</td> <td><input type="checkbox"/> Pathology Reports</td> </tr> <tr> <td><input type="checkbox"/> All Clinic Notes</td> <td><input type="checkbox"/> Progress Notes</td> <td><input type="checkbox"/> Billing Records: Payments/Adjustments</td> </tr> <tr> <td><input type="checkbox"/> All Hospital Medical Records (includes items in bold above)</td> <td><input type="checkbox"/> All Ambulatory Surgery Medical Records (includes items in bold above)</td> <td><input type="checkbox"/> Billing Records: UB/Itemized</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other Records - Specify Record Types(s) Not Listed Above _____</td> </tr> </table>		<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"/> Copies of Films/Images	<input type="checkbox"/> Lifeline EMS: Transport Record (Air/Ground)	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Rehab Records (PT/OT/ST)	<input type="checkbox"/> Immunization/Allergy Record	<input type="checkbox"/> Consultations	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> All Clinic Notes	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Billing Records: Payments/Adjustments	<input type="checkbox"/> All Hospital Medical Records (includes items in bold above)	<input type="checkbox"/> All Ambulatory Surgery Medical Records (includes items in bold above)	<input type="checkbox"/> Billing Records: UB/Itemized	<input type="checkbox"/> Other Records - Specify Record Types(s) Not Listed Above _____		
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<b>Special Authorization Section</b> *Per IC-16-39-2 this special authorization is valid for 180 days. _____																						
<b>Release Instructions:</b> How and when do you want the information? _____ 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 Date information is needed _____ NOTE: Please allow 30 days for processing																						
<b>Purpose of Release:</b> Why is it needed? _____																						
*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 180 days from the date signed unless otherwise specified (insert expiration if exceeds 180 days) _____ • 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 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.  _____ _____ _____ _____																						
<b>TO BE COMPLETED BY IU HEALTH:</b> Initials of person releasing information _____ Date _____ <input type="checkbox"/> ID Verified MRN _____ Patient Encounter Number _____																						



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Release of Information

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