Southern Indiana Physicians

Patient Authorization for Use and Disclosure of Protected Health Information

Name of Patient: _____ SSN: _____ DOB: _____

AUTHORIZATION IS GIVEN BY THE UNDERSIGNED TO RELEASE THE SPECIFIED PROTECTED HEALTH INFORMATION TO THE FOLLOWING INDIVIDUAL(S):

Name of Person Authorized to Receive Information:_____ DOB_____

Relationship to patient: _____

Protected Health Information To Be Released:

_____ Appointment Information
_____ Lab and Test Results
_____ Diagnosis and Treatment Information
_____ All Protected Health Information
_____ Other _____

I wish to be contacted in the following manner. Please cross through anything you don't want us using.

_____ Home telephone _____
___ Okay to leave a detailed message
___ Leave message to call back only

_____ Work telephone _____
___ Okay to leave a detailed message
___ Leave message to call back only

_____ Cell phone _____
___ Okay to leave a detailed message
___ Leave message to call back only

I the undersigned understand that I may REVOKE this authorization at any time, in writing, but the request shall remain valid until revoked or until the end of one year from date of signature, whichever occurs first, EXCEPT to the extent that action has been taken thereon. Information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the HIPPA rule. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information, unless I otherwise restrict such release of information.

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship, the personal representative of a deceased patient, or if no personal representative, the spouse or adult child of a deceased patient. If patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian. Emancipated minors may sign for themselves.

_____ _____ _____
(Signature of Patient) (Printed Name) (Date)

By initializing and dating below, I authorize this agreement to continue for another year unless I request a change in writing.

_____ _____ _____

_____ _____ _____