Date: _____ Medical Record Number _____

I hereby authorize **Henry Community Health** to release the following information, from the health record(s) of:

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

_____

Covering the period(s) of hospitalization, or outpatient services from:

Dates of service: _____

Information to be released:

☐ History and Physical ☐ Discharge Summary ☐ ED Record

☐ Operative Report ☐ Laboratory Report ☐ Radiology Report

☐ Radiology Image ☐ Other _____

Purpose of disclosure _____

Documents maintained in our electronic health record can be released on electronic media. Paper records must be released in paper format.

Information to be released by: ☐ Paper ☐ Electronic media

Unless otherwise indicated, this authorization extends to psychiatric, alcohol and/or drug abuse, and HIV information, if any, as may be contained in the hospital records.

Information is to be released to:

☐ Self

Name _____

Address _____

City/State/ Zip _____

Telephone ___( )_____ Fax ___( )_____

I understand this authorization can be revoked at any time except to the extent that disclosures made in good faith have already occurred in reliance on this authorization. To revoke this authorization please submit request in writing to the Henry Community Health medical records director. Include in the request your name, address, date of birth and whom the information was to be released to.

The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Once we have disclosed the information according to this authorization the information is subject to re-disclosure by the recipient.

We will not condition treatment on the completion of the authorization. *This consent expires 60 days from the date initiated.*

Signed _____ Date _____
(Patient or representative)

_____
(Relationship to patient)

Witness _____ Date _____

Date Received _____ Date Released _____ Personnel fulfilling request _____

Information released via ☐ Mail ☐ Fax ☐ In person Format ☐ Paper ☐ Electronic

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Dev/Rev: 3/00, 3/03, 7/12

Henry Community Health
New Castle, In 47362

RI0010