Patient Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone Number: - -

Information to be Released:

I hereby authorize Henry Community Health to release the following information

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

- ❑ Hospital Medical Records
- ❑ Physician Office Medical Records
- ❑ Radiology images

Provider/Office Name: _____

Only Record types checked below:

- ❑ Discharge Summary/Note
- ❑ History and Physical Exam
- ❑ Operative Report
- ❑ Consultations
- ❑ Other Records (specify record type(s) _____
- ❑ Radiology Reports
- ❑ Laboratory Reports
- ❑ Rehab Records (PT/ST/OT)
- ❑ Progress Notes
- ❑ Emergency Records
- ❑ Immunization/Allergy Records
- ❑ Pathology Reports

Unless otherwise indicated, this authorization extends to psychiatric, alcohol and/or drug abuse, Genetic and HIV information, if any, as may be contained in the Henry Community Health record.

Information to be Released to If Not Patient:

Name: _____

Address: _____ Fax Number: - -

City: _____ State: _____ Zip: _____ Phone Number: - -

Purpose of Release:

- ❑ Personal Use
- ❑ Continuing Care
- ❑ Transfer of Care
- ❑ Insurance Application
- ❑ Insurance Payment/Claim
- ❑ Litigation/Legal
- ❑ Social Security appeal
- ❑ Social Security Disability Determination
- ❑ Other _____

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

Information to be Released by:

❑ Mail ❑ CD ❑ Fax (patient care only) ❑ Hold for pickup ❑ Email _____

- 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.
- I understand this authorization will expire in 60 days from the date initiated unless otherwise specifed here. _____
- I understand that once HCH has disclosed the information according to this authorization the information is subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- HCH will not condition my treatment on the completion of the authorization.
- I understand that I am responsible for paying the applicable fees, if any. I have the right to an estimate of the fees before receiving a copy of the records.
- By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

Click here to sign

Patient/Authorized Representative Signature

Click here to sign

Witness Signature

Relationship to Patient: _____

For Internal Use Only

Date Received / / Date Released / / Pages _____

Patient Verified ❑ ID ❑ Signature ❑ Verbal Staff Initials _____