

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

____ 1600 Albany Street, Beech Grove, IN 46107 ____ 8111 S. Emerson Avenue, Indianapolis, IN 46237
____ 1201 Hadley Road, Mooresville, IN 46158 ____ Other St. Francis (specify): _____

I AUTHORIZE (facility name) TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S).

Patient Name (Please Print): _____

Patient Address: _____

Date of Birth: _____ Last 4 Digits of Social Security # _____ Patient Telephone #: _____

Covering the period(s) of treatment: _____

INFORMATION TO BE RELEASED:

____ Discharge Summary ____ Radiology (X-ray, CT Scan, MRI) ____ ER record
____ History & Physical ____ EKG ____ Lab Results
____ Operative Report ____ Consultations ____ UB04
____ Complete Health Record ____ Other (specify): _____

INFORMATION TO BE RELEASED TO:

Name: _____

Address: _____

City, State, Zip: _____

Telephone #: _____

PURPOSE OF DISCLOSURE: ____ Continuation of Care ____ Insurance ____ Attorney ____ Personal Use ____ Other

I understand this authorization can be revoked by me at any time in writing to (facility Name) except that disclosure made in good faith has already occurred in reliance on this authorization. (facility name) will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations.

I understand that a fee may be charged for preparing a copy of the requested records. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days

Your protected health information will be provided to you in paper format. If you wish for your protected health information to be provided to you on electronic media that meets the HIPAA and HITECH requirements, you must initial here: _____ . The password for accessing your electronic media is: _____ .

I understand that this release also pertains to records regarding the testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or for psychiatric treatment or counseling or communicable disease, unless I have initialed here:** _____ .

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT, if other than patient: _____

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable): _____

WITNESS SIGNATURE: _____ DATE: _____



St. Francis

Hospital & Health Centers
Sisters of St. Francis Health Services, Inc.

Patient Name: _____
Account #: _____
Medical Record #: _____

