

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

____ 1600 ALBANY STREET, BEECH GROVE, IN 46107

____ 8111 S. EMERSON AVENUE, INDIANAPOLIS, IN 46237

____ 1201 HADLEY ROAD, MOORESVILLE, IN 46158

____ Other St. Francis Site (specify) : _____

I authorize St. Francis Hospital and Health Centers to release the following information from the health record(s) of:

Patient Name (Please Print): _____

Date of Birth: _____ Social Security #: _____

Covering the period(s) of treatment: _____

INFORMATION TO BE RELEASED:

_____ Discharge Summary	_____ X-Ray, CT Scan, MRI	_____ ER Record
_____ History & Physical	_____ EKG	_____ Lab Results
_____ Operative Report	_____ Complete Copy of Health Record	
_____ Other (specify): _____		

INFORMATION RELEASED TO:

Name: _____

Address: _____

City, State, Zip: _____

Telephone #: _____

PURPOSE OF DISCLOSURE: _____

I UNDERSTAND THIS CONSENT CAN BE REVOKED BY ME AT ANY TIME EXCEPT TO THE EXTENT THAT DISCLOSURE MADE IN GOOD FAITH HAS ALREADY OCCURRED IN RELIANCE ON THIS CONSENT.

THIS CONSENT WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED. I ALSO UNDERSTAND THAT A FEE MAY BE CHARGED FOR PREPARING A COPY OF THE REQUESTED RECORDS.

THE FACILITY, ITS EMPLOYEES AND ATTENDING PHYSICIAN ARE RELEASED FROM LEGAL RESPONSIBILITY OR LIABILITY FOR THE RELEASE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.

I UNDERSTAND THAT RECORDS RELEASED MAY INCLUDE DRUGS AND ALCOHOL, MENTAL HEALTH, AND AIDS RELATED RECORDS, UNLESS I HAVE INITIALED HERE: _____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT ADDRESS: _____

PATIENT TELEPHONE #: _____

WITNESS SIGNATURE: _____ DATE: _____

If the signature is not that of the patient, please check one of the following:

_____ Patient is a minor _____ Request is from a current provider of care

_____ See attached document(s) giving authority to request records

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). These Federal rules prohibit you from making any further disclosure of this information, unless further disclosure is expressly permitted by patient or as otherwise permitted by the 42 CFR Part 2. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol patient.

PATIENT LABEL MUST
BE PLACED WITHIN
THIS BOX

