

**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 (specify): \_\_\_\_\_

**I AUTHORIZE ST. FRANCIS HOSPITAL AND HEALTH CENTERS TO RELEASE THE FOLLOWING INFORMATION FROM THE HEALTH RECORD(S) OF:**

Patient Name (Please Print): \_\_\_\_\_

Patient Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

Patient Telephone #: \_\_\_\_\_

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 TO BE RELEASED TO:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

**PURPOSE OF DISCLOSURE:** \_\_\_\_\_

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

**This authorization 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.** 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.

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: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



**St. Francis**

Hospital & Health Centers

Sisters of St. Francis Health Services, Inc.

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Release of Information

PATIENT LABEL MUST  
BE PLACED WITHIN  
THIS BOX

