AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize **WHITE COUNTY MEMORIAL HOSPITAL** (authorized entity) and its medical staff
(Hospital Physician, Clinic, etc)
and employees to disclose the following identified information contained in their medical records. . .

PATIENT INFORMATION:

Patient Name: _____ SSN: _____ *(Optional)* Date of Birth: ___/___/___

Patient Address: _____
Street Address City State Zip

INFORMATION TO BE RELEASED:

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

_____ Emergency Room Record	_____ Radiology Report	_____ Operative Report
_____ Discharge Summary	_____ Radiology Film(s)	_____ Nurses Notes
_____ History & Physical Report	_____ Pathology Report	_____ Outpatient Therapy
_____ Physician Orders	_____ Laboratory Tests	
_____ Other *(please specify)* _____		

TO BE RELEASED TO:

_____ Myself

Send to the following person: _____

_____

_____
(Address)

FOR THE PURPOSE OF:

____ Continued Care ____ Attorney ____ Insurance ____ Self ____ Other *(explain):* _____

I understand that the information in my health record may include information relating to mental health/drug, alcohol treatment and/or HIV, AIDS, or communicable disease. Unless initialed here, these records will be released with my health record. _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. I understand that the revocation will not apply to information that has already been released in response to this authorization. This Authorization shall remain valid until it is revoked or it expires. This authorization will expire in sixty (60) days per I.C. 16-39-1-1. If I choose I may specify an expiration date or event earlier than 60 days.
This Authorization will expire on: _____ (Expiration Date or Defined Event)

I understand that I am not required to sign this Authorization in order to receive health care treatment. I understand that I may inspect or copy the information to be disclosed, as provided in 42 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I further agree to pay the cost incurred in copying the medical records set forth by Indiana code 16-39-9-3.

_____ _____
Signature of Patient Date Signed

The signature of a parent (including a non-custodial parent provided that there are no court-ordered restrictions) or legal guardian is required for any unemancipated patient under the age of 18. A parent, guardian, or custodian may sign for an incompetent patient. The personal representative of the estate may sign for a deceased patient; if no personal representative, the spouse may sign for a deceased patient; if no spouse or personal representative, an adult child may sign for the deceased patient.

_____ _____
Signature of Other Authorized Person Date Signed

_____
Relationship of Other Authorized Person

TO BE COMPLETED BY HOSPITAL STAFF:

Initials of person releasing information: _____

Photo ID/ Signature Verified (*if not currently admitted*): _____

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