AUTHORIZATION TO RELEASE AND DISCLOSE HEALTH INFORMATION

Union Health

Miscellaneous and (0019)

Patient Information:

Name: _____ Date of Birth: _____ Phone: _____

Address: _____ City / State / Zip: _____ Email: _____

I, Authorize: _____

(Name of Hospital or Physician Practice who will disclose information)

Information to be Released/Obtained: **Date of Visit(s):** _____

- ☐ Procedure Report
- ☐ Progress Notes
- ☐ Consult Notes
- ☐ Abstract/Summary of Records
- ☐ Rehab Services
- ☐ Radiology Reports
- ☐ Lab and Pathology Reports
- ☐ Other: Please Specify: _____
- ☐ Cardiac Testing
- ☐ ER Reports
- ☐ Discharge Summary / Short Stay Note

Receiving Party: ☐ Myself ☐ Other (Provide information below)

Name: _____ Date of Birth: _____Phone: _____Fax: _____

Address: _____ City / State / Zip: _____ Email: _____

Special Authorization:

Federal and State laws protect the following information. Please indicate if you would like this information released in part of this authorization: (Include dates if applicable)

- Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No date: _____
- HIV Testing and Results ☐ Yes ☐ No date: _____
- Mental Health Records ☐ Yes ☐ No date: _____
- Psychotherapy Records ☐ Yes ☐ No date: _____

Purpose of Release:

- ☐ Personal Use or Insurance Application (Fees may be charged in accordance with 760 IAC 1-71-3 and 45 CFR 164.524)
- ☐ Litigation/Legal
- ☐ Other, including coordination or continuing care, or Social Security Benefits

Method of Release: (Default to paper if not marked)

☐ Paper ☐ CD (Imaging only) ☐ Fax (Healthcare Provider Only) ☐ Electronic Access (Email address above)

Acknowledgement:

- This authorization will expire in 6 months from the date signed.
- I understand that I have the right to revoke this authorization at any time and that the revocation will not apply to any information that has already been released in response to this authorization.
- I understand that my treatment, payment, enrollment, or eligibility benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule.
- I understand if this entity has received and used records received from other entities for treatment, these records may be released pursuant to this authorization.
- I understand this entity cannot prevent the redisclosure of your records by the receiving party under this authorization, and that information may no longer be protected under federal and state law after its release.
- I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____

Printed Name and Signature Date

_____

Authority to act on behalf of the patient
(Provide legal documentation)

TO BE COMPLETED BY UNION HEALTH STAFF:

Processed by: _____ Date: _____

Medical Record Number: _____

Encounter Number: _____

☐ Identity Verified ☐ Signature Verified