



Authorization to Release and Disclose Patient Information Form English

PATIENT INFORMATION	Name _____ Prior Name(s) _____ Date of Birth _____ Address _____ City _____ State _____ Zip _____ Phone _____
Clinic/Hospital/Health Care Provider: <small>Who has the information you want released? Please add the specific IU Health location and/or IU Health healthcare provider.</small>	Name IU Health, including _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Fax Number _____
Receiving Party: Choose One: <input type="checkbox"/> Me <input type="checkbox"/> Other Only one receiving party allowed per form. Where do you want the information sent?	Name _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Fax Number _____
Information to be Released: Dates of Service or Date Range is Required. What do you want sent or released? Check the appropriate box(es).	Date(s) of Service: From ____/____/____ To ____/____/____ <u>Only record types checked below (could include medical records such as paper, electronic, digital or verbal communications between IU Health and the receiving party):</u> <input type="checkbox"/> Discharge Summary/Note <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Emergency Record(s) <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Copies of Films/Images <input type="checkbox"/> Lifeline EMS: Transport Record (Air/Ground) <input type="checkbox"/> Operative Report <input type="checkbox"/> Rehab Records (PT/OT/ST) <input type="checkbox"/> Immunization/Allergy Record <input type="checkbox"/> Consultations <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> All Clinic Notes <input type="checkbox"/> Progress Notes <input type="checkbox"/> Billing Records: Payments/Adjustments <input type="checkbox"/> All Hospital Medical Records (includes items in bold above) <input type="checkbox"/> Billing Records: UB/Itemized <input type="checkbox"/> All Ambulatory Surgery Medical Records (includes items in bold above) <input type="checkbox"/> Other Records - Specify Record Types(s) Not Listed Above
Special Authorization Section *Per IC-16-39-2 this special authorization is valid for 180 days.	State and federal law protect the following information. If this information applies to you and you want these records released, then you must select "Yes" below. All "Yes" releases of the record types below include all medical records such as paper, electronic, digital or verbal communications between IU Health and the receiving party). Alcohol, Drug, or Substance Abuse Records <input type="checkbox"/> Yes HIV Testing and Results <input type="checkbox"/> Yes Mental Health Records* <input type="checkbox"/> Yes Psychotherapy Records <input type="checkbox"/> Yes Genetic Records <input type="checkbox"/> Yes Other Specific Instructions: _____
Release Instructions: How and when do you want the information?	Release Method/Format requested: (check one) <input type="checkbox"/> Electronic Access – E-mail address _____ <input type="checkbox"/> Paper <input type="checkbox"/> CD/DVD <input type="checkbox"/> Fax Date information is needed _____ NOTE: Please allow 30 days for processing
Purpose of Release: Why is it needed?	<input type="checkbox"/> Personal Use* <input type="checkbox"/> Insurance Application* <input type="checkbox"/> Social Security Appeal <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance Payment/Claim <input type="checkbox"/> Social Security Disability Determination* <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Litigation/Legal* <input type="checkbox"/> Other* _____ <small>*Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524</small>
<ul style="list-style-type: none"> • This authorization will expire in 180 days from the date signed unless otherwise specified (insert expiration if exceeds 180 days) _____ • I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above-named authorized entity. The revocation will not apply to information that has already been released in response to this authorization. • I understand that I am not required to sign this Authorization to receive health care treatment. • IUH's records may include records that it received from other organizations. If these records have been used by IUH, and filed in the record IUH maintains about you, these records may be released with your IUH records. • IUH cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release IUH from any and all liability resulting from a redisclosure by the recipient. 	
Your signature indicates that you have read and understand this form, and you authorize release of your information as described above. _____ Patient/Legal Guardian Signature Date _____ _____ Authority to act on behalf of patient (Attach documentation)	TO BE COMPLETED BY IU HEALTH: Initials of person releasing information _____ Date _____ <input type="checkbox"/> ID Verified MRN _____ Patient Encounter Number _____

