

AUTHORIZATION FOR THE USE OR DISCLOSURE OF  
HEALTH INFORMATION

By signing below, I hereby authorize Hendricks Regional Health and/or any of its affiliates to release my health information, as outlined, to be used or disclosed to the following person or facility:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_

For the Purpose of: \_\_\_\_\_

This authorization is only valid for 60 days. I have the right to revoke this authorization in writing, except if HENDRICKS REGIONAL HEALTH has taken action in reliance upon this authorization. Or, if this authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy. Hendricks Regional Health may charge any designated recipient the maximum allowable amount by law for medical record copies. Reasonable notice is required regarding notification and disclosure of Protected Health Information.

I may revoke this authorization by submitting a written Revocation Notice to:  
HENDRICKS REGIONAL HEALTH  
Attn: Health Information Management  
P.O. Box 409  
Danville, IN 46122

Disclosure made pursuant to this authorization may be subject to redisclosure by the recipient, and the law will no longer protect the privacy of my Protected Health Information. Hendricks Regional Health cannot be held liable for such redisclosures. Treatment cannot be conditioned upon obtaining this authorization.

**PATIENT INFORMATION:** Authorization to:  release information  view information  
Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Address \_\_\_\_\_ SS# \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Phone#: \_\_\_\_\_

**DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE DISCLOSED:**

(Please check records to be disclosed pursuant to this authorization)

**Dates of Treatment:** \_\_\_\_\_

**Medical record:**  Ancillary Results  Dictated Reports  Complete Record  Other: \_\_\_\_\_

**Mental Health Record:**  Ancillary Results  Dictated Reports  Complete Record  Other: \_\_\_\_\_

*Federal Regulation 42 CFR part 2 prohibits redisclosure of patient information without the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

HENDRICKS REGIONAL HEALTH may disclose the following Protected Health Information, in addition to the above Protected Health Information:

Substance Abuse Diagnosis:  Yes  No  N/A  
Communicable Disease Results (including HIV/AIDS):  Yes  No  N/A

**I acknowledge that I have read, understand and received a copy of this authorization.**

\_\_\_\_\_  
Signature of Patient Date Signature (Authorized Representative) Date

\_\_\_\_\_  
Printed Description of Authorized Representative's relationship/authority to sign for patient (i.e. Power of Attorney)

\_\_\_\_\_  
Signature of Witness Date

WHITE - Chart Copy

CANARY - Patient

