Hendricks Regional Health

Authorization for the Use or Disclosure of Heath Information

By signing below, I authorize Hendricks Regional Health, DBA Indiana Adult & Pediatric Medicine 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 _____ Phone _____

Address _____

For the purpose of: ☐ Personal ☐ Insurance ☐ Attorney ☐ Other _____

Changing Doctor due to: ☐ Moving ☐ Insurance ☐ Referred to specialist ☐ Dissatisfied with HRH/physician

Patient Information:

Patient Name: _____ DOB _____

Address _____ SSN __XXX-XX-_____

City/State/Zip _____ Phone _____

Description of Protected Health Information to be Disclosed:

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

How information is to be disclosed: ☐ Copy & release information ☐ View information

Dates of Treatment: _____

Medical Record: ☐ Visit notes ☐ Lab/x-ray reports ☐ Immunization records ☐ Other _____

Provide Medical Record copies in the following format:

☐ Paper ☐ Electronic ☐ E-mail _____

I understand that visit notes may include use of tobacco and alcohol, depression, ADD/ADHD etc.

- 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.
- My Protected Health Information that is used or disclosed under the authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by law. Hendricks Regional Health cannot be held liable for such re-disclosures.
- Treatment cannot be conditioned upon obtaining this authorization.
- **Hendricks Regional Health will charge me,** or any designated recipient, the maximum allowable by law for medical record copies.
- Reasonable notice is required regarding notification and disclosure of Protected Health Information (PHI).

I may revoke this authorization by submitting a written Revocation Notice to: HRH Health Information Management
PO Box 409
Danville, IN 46122

By signing below, I am authorizing the release of the Protected Health Information outlined above and acknowledge I have **read, understand and received a copy of this authorization**.

_____ _____
Signature of Patient Date

_____ _____
Signature (Authorize Representative) Date

_____
Printed Name

_____
Description of Authorized Representatives relationship/ authority to sign for patient (i.e. Power of Attorney)

_____
Signature of Witness

_____
Date