Hendricks Regional Health

Authorization for the Use or Disclosure of Heath Information

By signing below, I authorize Hendricks Regional Health, DBA Avon Family 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 _____ 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 _____
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 ☐ Verbal

Dates of Treatment: _____

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

Provide Medical Record copies in the following format:

☐ Paper ☐ Electronic via e-mail _____

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 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