Hendricks Regional Health

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

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.

Revocation Notice must be submitted in writing to: HRH Health Information Management
P.O Box 409
Danville, IN 46122

Provide Medical Record copies in the following format:
☐ Paper ☐ Electronic Email:____

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 ☐ verbal release

Patient Name ____D.O.B. ______________
Address ____ SS# XXX-XX-__________
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 ☐ Billing ☐ D/C Instruct
☐ 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, understood 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. NOTE: Representatives other than parents of minors must attach proof of authority to this request.

______________________________ ________________
Signature of Witness Date

WHITE - Chart Copy CANARY – Patient