AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

All portions of this form must be completed, or this request will not be processed.

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____ Phone Number:_____

Address:_____ City:_____ State:_____ Zip Code:_____

PROVIDER OR ENTITY TO RELEASE INFORMATION

Name:_____ Phone:_____ Fax: _____

Address:_____ City:_____ State:_____ Zip Code:_____

INDIVIDUAL, PROVIDER OR ENTITY TO RECEIVE INFORMATION

I hereby authorize the above named provider or entity to release health information to:

Name:_____ Attention:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

DELIVERY METHOD

☐Fax Copy to individual/entity noted above ☐Mail Copy to individual/entity noted above ☐Please mail separate copy to patient

PURPOSE FOR RELEASE OF INFORMATION

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):

☐Treatment or Consultation ☐ At the Request of Patient ☐ At the Request of the Employer ☐ Billing or Claim Payment

☐Other (specify)_____

INFORMATION TO BE RELEASED

Health information that may be released is limited to the following date(s) of service:

From: _____ To _____

From: _____ To _____

Health information that may be released is limited to the following:

☐**Entire Patient Record**

☐Medical History (e.g. history & physical, consults, operative reports, discharge summary)

☐History/Physical Exams ☐ Outpatient Clinic Notes/Encounters ☐ Labs/Pathology Reports ☐ Radiology/Imaging Reports

☐Emergency Department ☐ Operative Reports ☐Discharge Summary ☐ Medications

☐Billing ☐Other (specify)_____

I specifically authorize the release of the following restricted health information:

☐Drug, Alcohol or Substance Abuse Treatment ☐ Mental Health Treatment & Notes ☐ HIV/AIDS Related Records

THIS IS A LEGAL DOCUMENT

Please read the following carefully. By signing below, you attest that you understand and agree to the terms and conditions of this consent for release of protected health information.

I understand that:

1) I have the right to refuse to sign this authorization, but refusal may result in an improper diagnosis or treatment, denial of coverage.
2) This authorization may be revoked at any time by sending written notification to the Health Information Management Department, **except** where this authorization has already been acted on for release of my protected health information.
3) The health information released may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. One to One health will not condition my treatment on whether I provide authorization for the requested use or disclosure.
4) I am entitled to receive a signed copy of this authorization, upon request. A copy of this authorization shall be as valid as the original.
5) Unless listed above, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.

Unless earlier revoked this authorization will expire ninety (90) days after the date the document is signed.

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Patient/Legal Representative Printed Name Authorized Witness

**If signed by a legal representative; state the relationship and identify below the authority to act on the individual's behalf.*

Patient Is: ☐A Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Representative is: ☐Custodial Parent ☐Legal Guardian ☐ Power of Attorney Health Care
☐Executor of Estate of the Deceased ☐ Authorized Legal Representative ☐ Other:_____