

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ **Birth Date** _____

Patient Address _____

Telephone _____ **Social Security Number** _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure (give name, address and phone):

3. The information I authorized disclosed is:
From (date) _____ to (date) _____

___ Abstract of Medical Records	___ Any and All (Medical Records)
___ Entire Medical Record	___ Billing/Itemized Statements
___ X-rays and Imaging Films	___ Other: _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty (60) days.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have a question about disclosure of my health information, I can contact the Director of Health Information Services.
8. I understand there may be a fee for copying these records in accordance with 45 CFR 164.524 and IC 16-39-9-3.
9. I authorize _____, or a representative therefrom, to pick up the requests copies of my record and understand that they must be able to prove their identity with a valid driver's license or state identification card.

Signature of Patient or Legal Representative

Date

Signature by Legal Representative, Relationship to Patient

Signature of Witness (if not signed by patient)