Indiana University Health

Authorization to Release and Disclose Patient Information Form English

PATIENT INFORMATION

Name _____ Prior Name(s) _____

Date of Birth _____ Address _____

City _____ State _____ Zip _____ Phone _____

Clinic/Hospital/Health Care Provider:

Who has the information you want released? Please add the specific IU Health location and/or IU Health healthcare provider.

Name IU Health, including _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Receiving Party:

Choose One:

☐ Me ☐ Other

Only one receiving party allowed per form.

Where do you want the information sent?

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Information to be Released:

Dates of Service or Date Range is Required.

What do you want sent or released? Check the appropriate box(es).

Date(s) of Service: From ____/____/____ To ____/____/____

Only record types checked below (could include medical records such as paper, electronic, digital or verbal communications between IU Health and the receiving party):

☐ **Discharge Summary/Note**	☐ **Radiology Reports**	☐ Emergency Record(s)
☐ **History & Physical Exam**	☐ Copies of Films/Images	☐ Lifeline EMS: Transport Record (Air/Ground)
☐ **Operative Report**	☐ Rehab Records (PT/OT/ST)	☐ Immunization/Allergy Record
☐ **Consultations**	☐ **Laboratory Reports**	☐ **Pathology Reports**
☐ All Clinic Notes	☐Progress Notes	☐Billing Records: Payments/Adjustments
☐ All Hospital Medical Records (includes items in **bold** above)		☐Billing Records: UB/Itemized
☐ All Ambulatory Surgery Medical Records (includes items in bold above)		
☐ Other Records - Specify Record Types(s) Not Listed Above _____		

Special Authorization Section

*Per IC-16-39-2 this special authorization is valid for 180 days.

State and federal law protect the following information. If this information applies to you and you want these records released, then you **must** select "Yes" below. All "Yes" releases of the record types below include all medical records such as paper, electronic, digital or verbal communications between IU Health and the receiving party).

Alcohol, Drug, or Substance Abuse Records	☐ Yes
HIV Testing and Results	☐ Yes
Mental Health Records*	☐ Yes
Psychotherapy Records	☐ Yes
Genetic Records	☐ Yes

Other Specific Instructions: _____

Release Instructions:

How and when do you want the information?

Release Method/Format requested: (check one)

☐ Electronic Access – E-mail address _____

☐ Paper ☐ CD/DVD ☐ Fax

Date information is needed _____ NOTE: Please allow 30 days for processing

Purpose of Release:

Why is it needed?

☐ Personal Use*	☐ Insurance Application*	☐ Social Security Appeal
☐ Continuing Care	☐ Insurance Payment/Claim	☐ Social Security Disability Determination*
☐ Transfer of Care	☐ Litigation/Legal*	☐ Other* _____

*Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

- This authorization will expire in 180 days from the date signed unless otherwise specified (insert expiration if exceeds 180 days) _____
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above-named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this Authorization to receive health care treatment.
- IUH's records may include records that it received from other organizations. If these records have been used by IUH, and filed in the record IUH maintains about you, these records may be released with your IUH records.
- IUH cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release IUH from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form, and you authorize release of your information as described above.

_____ _____

Patient/Legal Guardian Signature Date

_____

Authority to act on behalf of patient (Attach documentation)

TO BE COMPLETED BY IU HEALTH:

Initials of person releasing information____ Date _____

☐ ID Verified

MRN _____

Patient Encounter Number _____