



225 Crosslake Drive
Evansville, IN. 47715
Phone: 812-477-1558
Fax: 812-476-6867

Authorization for the Release of Protected Health Information

Patient Name: _____ SS#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Birthdate: _____

Release From: _____

(Name and address of Organization, Agency or Physician)

Release To (Person or Class of Persons authorized to receive my Protected Health Information):

Name: _____

Address: _____

Reason for release:

- Continuing medical care
- Claim for reimbursement
- Litigation against third party other than the Practice, a Practice employee, or physician
- Litigation against the Practice, a Practice employee or physician (specify person): _____
- At the request of the Patient or the Patient's representative
- Other: _____

Specified information to be released:

Date(s) of treatment: _____ Type of Treatment _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> X-Ray Disc | <input type="checkbox"/> X-Ray Films (\$10 per sheet) |

Authorization:

I understand that the information disclosed may contain testing or treatment information relating to mental health, drug and/or alcohol abuse treatment, sexually transmitted diseases, HIV/AIDS virus.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulation.

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Medical Records department providing that the information has not already been disclosed.

I understand that refusal to sign this authorization does not condition treatment.

I understand that the authorization will expire sixty (60) days from the date signed unless otherwise specified.

Date, event or condition on which authorization will expire if other than 60 days: _____

Patient Signature: _____ Date Signed: _____

Must be signed by parent or legal guardian if under 18

Signature of Other Authorized Person: _____ Relationship: _____