DEACONESS HEALTH SYSTEM
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name:	**Birth date:**	**Last 4 digits Social Security Number**
Address:		**Telephone:**

I AUTHORIZE RELEASE OF RECORDS

FROM	**TO**
☐ Deaconess Hospital, Evansville, IN (includes Gateway) ☐ Deaconess Cross Pointe Hospital, Evansville, IN ☐ The Heart Hospital, Newburgh, IN ☐ The Women's Hospital, Newburgh IN ☐ Deaconess Clinic, Evansville, IN Specify:_____ ☐ Progressive Health, Evansville, IN ☐ High Pointe Rehab, Newburgh, IN ☐ Other: Specify name and address _____ _____ _____	Name:_____ Facility_____ Address: _____ _____ Telephone: _____ Fax: _____ Email: _____ **PURPOSE** ☐ Personal copy ☐ Continuing care ☐ Litigation against facility/doctor ☐ Litigation against a party other than the facility/doctor ☐ Other:Specify**:**_____

Release the following

Dates of Service:_____ ☐ Inpatient ☐ Outpatient ☐ Physician Office

☐ Complete record	☐ HIV results
☐ History and Physical	☐ Radiology results
☐ Doctor/provider notes	☐ Substance abuse records
☐ Medication record	☐ Mental health record
☐ Labs (**other than HIV**)	☐ Other: Specify: _____
☐ Immunizations	_____
	_____
	_____

- This Authorization is valid for 60 days from date of signature below unless specified otherwise here: _____
- This Authorization may be revoked by contacting the Medical Records Custodian of the above selected facility. Records released prior to revocation cannot be recalled.
- We will provide treatment to you even if you do not authorize release of your records unless the sole purpose for the service is to generate information to be released.
- Records released (other than alcohol/substance abuse records) may be subject to re-release and no longer protected by federal privacy law. Alcohol/substance abuse records may not be re-released without your authorization.

How do you want these delivered? ☐ Personal pickup ☐Via mail (☐ paper or ☐ CD) ☐ Via fax ☐ Via email
Deaconess will encrypt records sent on electronic media. You may request that an electronic record sent to you be unencrypted; however, be advised that an unencrypted CD or email is not secure and can be opened and read by parties other than you.
☐ **Do NOT encrypt.**

_____ _____
Patient Signature Date Signed

_____ _____
Signature of Other Authorized Person Relationship to Patient

Persons who can authorize release of records: Patients age 18 and over, emancipated minors, parents of unemancipated minors, minors consenting in their own right to certain procedures, lawful personal representatives (must show proof of appointment). For deceased patient, records may be obtained by the estate representative, or spouse if no representative, adult children if no spouse, or parent if no children, or guardian/custodian of a minor child.