## 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  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	TO  Name: Facility Address:  Telephone: Fax: Email:  PURPOSE  Personal copy  Continuing care	
	☐ Litigation again☐ Litigation again	
Dates of Service:  Complete record History and Physical Doctor/provider notes Medication record	ne following Inpatient	
<ul> <li>This Authorization is valid for 60 days from date of signature below unless specified otherwise here:</li></ul>		
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.

F- 5085\* (09-13)