AUTHORIZATION TO RELEASE MEDICAL INFORMATION

DEACONESS HOSPITAL, INC. • Evansville, IN 47747

Name of Patient:		**Social Security Number:**	**Address of Patient:** Street _____
Telephone Number: ( )	**Birthdate:**	**Age:**	City _____ State Zip

AUTHORIZATION IS GIVEN BY THE UNDERSIGNED TO RELEASE THE INFORMATION SPECIFIED BELOW:

FROM	Name of organization or Person to RELEASE information: _____ Street _____ City _____ State _____ Zip _____
TO	Name of organization or Person to RECEIVE information: _____ Street _____ City _____ State _____ Zip _____

THE INFORMATION IS REQUESTED FOR THE FOLLOWING PURPOSE:

- ❑ Continuing medical care
- ❑ Claim for reimbursement
- ❑ Litigation against third party other than the Hospital, a Hospital employee, or a physician
- ❑ Litigation against the Hospital, a Hospital employee, or a physician (*Specify*) _____

  _____

- ❑ Other (*Specify*) _____

I understand that this authorization can be revoked by me at any time by submitting a written request to _____
I understand that revocation will not apply in those instances specified in the applicable Notice of Privacy Practices.
I understand that the material released as a result of this authorization may be subject to redisclosure and no longer protected by the laws applying to medical information release.
I understand that the Hospital cannot require my signature on this document as a condition for providing treatment or obtaining payment unless the sole purpose of the procedure is to create information to be released. I further understand that if my signature on this form is a requirement for the procedure to be performed and I refuse to sign, the procedure will not be performed and the requesting party will be notified.
This authorization will expire 60 days after date signed unless otherwise specified as follows: _____

INFORMATION TO BE RELEASED

Dates of treatment:	Type of treatment: ❑ Inpatient ❑ Emergency Room ❑ Outpatient

- ❑ Face Sheet
- ❑ History & Physical
- ❑ Discharge Summary
- ❑ Consultation Report
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Emergency Room Report
- ❑ Entire Record

- ❑ X-ray Reports (*Specify type or all*) _____
- ❑ Laboratory Reports (*Specify type or all*) _____
- ❑ HIV Results
- ❑ Other (*Specify*) _____

_____ (Signature of Patient)

_____ (Date Signed)

_____ (Signature of Other Authorized Person)

_____ (Relationship to Patient)

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship, the personal representative of a deceased patient, or if no personal representative the spouse of a deceased patient, or if no spouse, any adult child of a deceased patient. If patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian. Emancipated minors may sign for self.

RELEASE INFORMATION AS INDICATED:

☐ I Will Pick Up the Info from Deaconess Hospital Medical Records
Please call me when ready at: _____

☐ Mail Info to the Person/ Organization indicated in the "To" section above.
Date of Appointment: _____