**DEACONESS HEALTH SYSTEM**
**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

| **Name of Patient:** | **Patient Birth Date:** | **Last 4 Digits Pt SSN:** |
|---|---|---|
| **Patient Address: (Street, City, State and Zip)** | **Patient Telephone:** | |

## I AUTHORIZE RELEASE OF RECORDS

**RELEASE FROM**

- ☐ Deaconess Hospital, Evansville, IN (includes Gateway)
- ☐ The Heart Hospital, Newburgh, IN
- ☐ The Women's Hospital, Newburgh IN
- ☐ Deaconess Clinic, Evansville, IN
  Office of:_____
- ☐ Evansville Surgery Center, Evansville, IN
- ☐ Deaconess Cross Pointe Hospital, Evansville, IN
  *(Behavioral health records)*
- ☐ ProgressiveHealth, Evansville, IN
  *(Outpatient rehab records)*
- ☐ Other: Specify name and address

_____
_____
_____

**RELEASE TO**

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**:**_____
_____
***(Required if request is from someone other than patient or treating provider)***

### Release the following

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

- ☐ Doctor/Provider notes
- ☐ Medication Record
- ☐ Labs **(other than HIV)**
- ☐ Radiology results
- ☐ Immunizations
- ☐ HIV results
- ☐ Substance abuse records
- ☐ Mental health record
  - ☐ Psychological test results only
- ☐ Other: Specify:_____

_____

- This Authorization is valid for 60 days from date of signature below unless specified otherwise here: _____
- This Authorization may be revoked by writing to the Medical Records Custodian at the RELEASE FROM 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 ☐Mail (☐ paper or ☐ CD) ☐ Fax ☐ Email ☐MyChart
*Deaconess will encrypt records sent on electronic media. You may request that an electronic record sent to you be unencrypted; however, be aware 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.