WISHARD HEALTH SERVICES

Pricing for Patients:

\$1 per page for pages 1-10 .50 per page for pages 11-50

.25 per page for pages 51+ 1001 W. 10th Street, Indianapolis, Indiana Additional fee for postage and sales tax. **AUTHORIZATION FOR THE RELEASE OF INFORMATION** 3/12 YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAYBE RETURNED TO YOU TO BE COMPLETED. 1.) Identity: Patient Name: S.S. Number: ___ Address: City/State/Zip: _____ Date of Birth: _____ Phone #: _____ 2.) Type of release: Paper copies of the information Onsite review of information Verbal release permitting staff to discuss care 3.) Sender and receiver: I authorize the release of medical information (as indicated). Please provide complete mailing addresses. From: Release To: ___ By Mail _____ (Facility to information) ☐ I would like to pick up information. Please call: ___ **4.) Timeframe:** I would like information from the following dates: ____ ____ through ____ 5.) What to release: Please check the information you would like released ☐ INPATIENT ☐ OUTPATIENT Records related to (specify): ___ Records related to (specify): ___ ☐ Discharge Summary Operative Report(s) Clinic Notes X-Ray Report(s) ☐ Pathology Report(s) X-Ray Report Pathology Report(s) ☐ ER Notes ☐ Ambulance Run ☐ Lab Report(s) ☐ History & Physical ☐ Laboratory Report(s) ☐ Biopsychosocial Assessment ☐ Treatment Plan Other (specify): __ Other (specify): _ Pharmacy 6.) Release for special protected information: I authorize the release of information pertaining to communicable diseases and drug & alcohol abuse treatment records as protected by 42 CFR Part 2: a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS). ☐ YES □ NO/NA b. The diagnosis or treatment of alcohol and/or substance abuse. c. The treatment and/or consultation for mental health or psychological conditions ☐ YES ☐ NO/NA Note to recipient of information released under paragraph 6.) b.: This information has been disclosed to you from records protected by federal confidentiality rules - namely 42 CFR Part 2. Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse. 7.) Purpose for the release: Check one Health Care Insurance Legal Other (specify): ___ 8.) Expiration date: This authorization will expire in 60 days unless otherwise indicated or in the following event ___ condition I understand this Authorization can be revoked at any time, verbally or in writing, unless action has been taken in reliance on it. Treatment, payment, enrollment in any health plan or eligibility is not conditioned upon signing this Authorization. Unless covered by paragraph 6.) above once this information is released, it is not protected by Wishard Health Services and may potentially be redisclosed by the party who receives this information. I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of this information. Date

If patient is unable to sign, secure consent of legal representative and indicate reason. Proof of designation must be filed in record or sent along with request.

Signature of Patient	
Signature of Legal Representative and Relationship to Patient	Depart
Reason	Releas ——— Date:

ment Use Only ed by: _____



Signature of Witness