WISHARD HEALTH SERVICES
1001 W. 10th Street, Indianapolis, Indiana

Pricing for Patients: $1 page for pages 1-10
.50 page for pages 11-50
.25 page for pages 51+

Rev. 3/11

AUTHORIZATION FOR THE RELEASE OF INFORMATION

YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAYBE RETURNED TO YOU TO BE COMPLETED.

1.) Identity:

You must complete all the information in this area.

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: *(Facility to release information)*

Wishard or the facility you are needing the medical records from.

Release To:

Your name, address, City, State, Zip or the name, address, City, State, Zip of who you are releasing the information to.

☐ By Mail _____

☐ I would like to pick up information. Please call: _____

THIS MUST ALL BE FILLED OUT EVEN IF IT IS YOU.

4.) Timeframe: I would like information from the following dates: *The dates you had the service done.* through *The dates you had the service done.*

5.) What to release: Please check the information you would like released *Check off what you are needing.*

☐ *INPATIENT*
☐ Records related to (specify): _____
☐ Discharge Summary ☐ Operative Report(s)
☐ X-Ray Report ☐ Pathology Report(s)
☐ History & Physical ☐ Laboratory Report(s)
☐ Other (specify): *If wanting all, check "Other" and print"All"*

☐ *OUTPATIENT*
☐ Records related to (specify): _____
☐ Clinic Notes ☐ X-Ray Report(s) ☐ Pathology Report(s)
☐ ER Notes ☐ Ambulance Run ☐ Lab Report(s)
☐ Biopsychosocial Assessment ☐ Treatment Plan
☐ Pharmacy ☐ Other (specify): *If wanting all, check "Other" and print"All"*

6.) Release for special protected information: *Read and check Yes or No/NA - you must answer all questions.*

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. ☐ YES ☐ NO/NA > *You must answer all questions.*
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 indicated : Please change the expiration period to last _____

- I understand this Authorization can be revoked at any time according to Wishard Health Services' Notice of Privacy Practices. This request must be made in writing and sent to the same place that the release was made. Attach a copy of this release, if possible.
- Treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on 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 and Sign

_____
Date

_____
Signature of Patient

If you are not the patient signing this form, you must provide guardianship or POA documentation.

_____
Signature of Legal Representative and Relationship to Patient

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.

_____
Reason

_____
Signature of Witness

Department Use Only

Released by: _____

_____

Date: _____

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White--Individual/Entity to Release Information
Yellow--Patient
CON-79

Release Of Information
SAP# 200075
F#-000544