# ESKENAZI HEALTH

720 Eskenazi Ave., Indianapolis, Indiana

8/18

## AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

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

**Patient Information:**

Patient Name: _____

Date of Birth: _____ Last 4 digits of SS# _____

Address: _____

City/State/Zip: _____

Day Phone #: _____

**Type of release:**

☐ Paper copies of the information ☐ Onsite review of information ☐ Verbal release permitting staff to discuss care

**Sending and Receiving Party:** I authorize the release of medical information (as indicated). Please complete mailing address.

**From:**

Name _____

Address _____

City/State/Zip _____

Fax _____

**Release To:**

Name _____

Address _____

City/State/Zip _____

Fax _____

**Information to be release:** What do you want released? Check the appropriate box(es).

Date of Service from _____ through _____

☐ Complete Health Record (Records will include ALL types of records below including those records in Special Authorization Section unless indicated otherwise.

| | | | |
|---|---|---|---|
| ☐ Inpatient Records | ☐ Pathology Report(s) | ☐ Outpatient Records | ☐ Consultations |
| ☐ Discharge Summary | ☐ Radiology Report(s) (X-ray, CT Scan, MRI) | ☐ Emergency Room | ☐ Copies of Films / Images |
| ☐ History & Physical | ☐ EKG | ☐ Laboratory Report(s) | ☐ Immunizations |
| ☐ Operative Report (s) | ☐ Pharmacy | ☐ Clinic Notes | |

**Special Authorization Section:** Federal Regulations (42 CFR Part 2) and State Law (IC 16-39-2) protect the following information. If this information applies to you, please check "NO" if you do NOT want this information released (include dates where appropriate):

| | | | | | |
|---|---|---|---|---|---|
| Diagnosis, referral, and treatment for alcohol/substance abuse* | ☐ Yes | ☐ No | Sexually transmitted diseases | ☐ Yes | ☐ No |
| Communicable Diseases (includes HIV/AIDS status and treatment) | ☐ Yes | ☐ No | Genetic testing | ☐ Yes | ☐ No |
| Mental health treatment or counseling records | ☐ Yes | ☐ No | | | |

*Federal law/42 CFR Part 2 prohibits unauthorized disclosure of these records.

**Purpose of Release:** Why is it needed?

☐ Continuation/Transfer of Care ☐ Insurance Eligibility/Billing* ☐ Legal/Litigation* ☐ Request of the Individual* ☐ Other _____

*Fees may be charged in accordance with Federal Rule 45 C.F.R. §164.524 and Indiana law.

**Dates of service:**

I understand this authorization can be revoked at any time in writing to Eskenazi Health except if disclosure made in good faith has already occurred in reliance on this authorization. Eskenazi Health will not condition treatment, payment enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations. I understand that a fee may be charged for preparing a copy of the requested records. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

**Release instructions:** How and when do you want the information?

Your protected health information will be provided to you in paper format. If you wish for your protected health information to be provided to you in a secure electronic form, you must initial here: _____. Documents will be provided in a .pdf file format.

Select the electronic format: ☐ CD/DVD ☐ Email ☐ My Chart Patient Portal Email address records should be sent to: _____

_____ By initialing here, I understand that unencrypted e-mail or media (e.g., CD, DVD, etc.) is not considered a confidential means of communication. I have been offered a secure method to receive my records and I have chosen to receive without the protection of encryption. I agree to waive any rights that I may have against Eskenazi Health, any affiliated organization, or physician, or the suppliers, for any compromised information due to the technical failures and/or unintended breach of confidentiality.

I understand this release pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC16-39-2) concerning hospitalization, treatment or referrals, including but not limited to, information regarding treatment and related services for alcohol and/or substance abuse, communicable diseases, HIV and/or AIDS, or mental health treatment or counseling. My signature below indicates that I have read and understand this form, received a copy, and authorize the release of my information as described above.

_____
Date

_____
Signature of 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.

_____
Signature of Legal Representative and Relationship to Patient

_____
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
Form# EH200075