Daviess Community Hospital
An Affiliate of Ascension St Vincent

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Day Phone _____

Clinic/Hospital/Health Care Provider:
(Who has the information you want released? Please list the specific Hospital and/or clinic.)

Name _____

Address _____

City _____ State _____ Zip _____

Receiving Party:

(Where do you want the information sent? Who may have the information?)

Name _____

Address _____

City _____ State _____ Zip _____

Fax Number _____ Attention to _____

Information to be Released:

(What do you want sent or released? Check the appropriate box.)

☐ Physician Office Medical Records
☐ Hospital Medical Records Date(s) of Service: From _____/_____/_____ To _____/_____/_____
☐ Billing Records
☐ Copies of Films/Images
☐ Any and all records (includes ALL types of records listed below. If you want to include images and billing records, check those boxes.)

Only record types checked below:

☐ Discharge summary/note
☐ History & Physical Exam
☐ Operative report
☐ Consultations
☐ Radiology reports
☐ Rehab records (PT/OT/ST)
☐ Laboratory reports
☐ Progress Notes
☐ Emergency record(s)
☐ Immunization/allergy record
☐ Pathology reports
Other_____

Special Authorization Section

(Per IC-16-39-2 this special authorization is valid for 180 days.)

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol or Substance Abuse Records	☐ Yes ☐ No	Dates of service:
HIV Testing and Results	☐ Yes ☐ No	
Psychotherapy Records	☐ Yes ☐ No	_____
Genetic Records	☐ Yes ☐ No	

Release Instructions:

(How and When do you want the information?)

Release Method/Format requested: (check one) ☐ Electronic Access

☐ Paper ☐ CD/DVD ☐ View my record ☐ Fax (patient care only) _____
E-mail address for link

Date information is needed _____ NOTE: Please allow 5-10 business days for processing

Purpose of Release:

(Why is it needed?)

☐ Continuing care ☐ Personal Use ☐ Social Security Appeal
☐ Insurance application ☐ Litigation/Legal ☐ Social Security Disability Determination*
☐ Insurance payment ☐ Transfer of Care ☐ Other*_____

*Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

This will expire in 60 days from the date signed unless otherwise specified _____

I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above-named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.

I understand that I am not required to sign this Authorization in order to receive health care treatment.

DCH's records may include records that it received from other organizations. If these records have been used by DCH, and filed in the record DCH maintains about you, these records may be released with your DCH records.

DCH cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release DCH from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form, and you authorize release of your information as described above.

_____ _____
Patient/Legal Guardian Signature Date

_____
Authority to act on behalf of patient (Attach documentation)

To be completed by Hospital Staff:
Initials of person releasing information_____ Date_____
Photo ID/Signature Verified (if not currently admitted) _____
MRN_____ Patient Encounter Number_____