Hendricks Regional Health

AUTHORIZATION FOR DISCLOSURE OR REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Form #8014 Rev. 05/21

Instructions: To obtain access to protected health information maintained by Hendricks Regional Health ("HRH") or to authorize the use and disclosure of your protected health information by and/or to HRH, please complete the information below and sign in the space provided.

By signing below, I hereby authorize _____ to
Address: _____
☐ Release to ☐ Receive From ☐ Release to and Receive From
the entity or person below my health information, as outlined herein, to be used or disclosed for purposes described herein:

Name _____
Address _____
City, State, Zip _____
Phone # _____
Email/Fax _____

For the Purpose of: ☐ Personal ☐ Insurance ☐ Attorney ☐ Other _____
Changing Doctor due to ☐ Moving ☐ Insurance ☐ Referred to specialist ☐ Dissatisfied with HRH/physician

This authorization is valid for 60 days unless I identify a different period of time here: _____.
I have the right to revoke this authorization in writing, except if Hendricks Regional Health has taken action in reliance upon this authorization, or, if this authorization was given as a condition of obtaining insurance coverage, where other law provides that the insurance company has the right to contest a claim under the insurance policy. Hendricks Regional Health may charge any designated recipient fees as permitted by applicable law for medical record copies or access. Revocation Notice must be submitted in writing to:

HRH Health Information Management
252 Meadow Drive
Danville, IN 46122

Provide Medical Record copies in the following format: ☐ Paper ☐ Electronic
Delivery Method: ☐ Mail ☐ Pick-Up ☐ Fax ☐ Secure Email ☐ Other – describe: _____

I understand disclosure made pursuant to this authorization may be subject to redisclosure by the recipient, and the law may no longer protect the privacy of my Protected Health Information. Hendricks Regional Health cannot be held liable for such redisclosures. Hendricks Regional Health is not conditioning treatment, payment, enrollment, or eligibility for benefits on the provision of this authorization.

PATIENT INFORMATION: Authorization to permit: ☐ release information ☐ view information ☐ verbal release

Patient Name _____ D.O.B. _____
Address _____ SS# XXX-XX-_____
City, State, Zip _____ Phone#: _____

DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE DISCLOSED:
(Please identify records to be disclosed pursuant to this authorization)
Dates of Treatment (insert relevant dates or time frame): _____
Medical record: ☐ Ancillary Results ☐ Dictated Reports ☐ Complete Record ☐ Billing ☐ Discharge Instructions
☐ Other: _____
Mental Health Record: ☐ Ancillary Results ☐ Dictated Reports ☐ Complete Record ☐ Billing
☐ Other: _____

HENDRICKS REGIONAL HEALTH may disclose the following Protected Health Information, in addition to the above identified Protected Health Information:

Substance Use Disorder Records: ☐ Yes ☐ No ☐ N/A
Notice: 42 CFR part 2 prohibits unauthorized disclosure of these records. They may not be re-disclosed except in compliance with 42 CFR Part 2.

Communicable Disease Records (including HIV/AIDS): ☐ Yes ☐ No ☐ N/A
Notice: Indiana law requires specific patient authorization to release medical records related to a patient's communicable disease status, including HIV/AIDS, to protect their privacy.

I acknowledge that I have read, understood, and received a copy of this authorization. I hereby expressly authorize Hendricks Regional Health's to release the information described above in their possession related to my medical care to the person or entity identified above at such person or entity's request, including any information related to communicable diseases (including HIV/AIDS) and substance use disorders where indicated above.

_____ _____ _____ _____
Signature of Patient Date Signature (Authorized Representative) Date

_____ _____
Printed Authorized Representative's relationship/authority to sign for patient. NOTE: Unless a parent of a minor patient, you must attach proof of authority to this request.

ΔΙΣΧΛΟΣΕ

_____ _____
Signature of Witness Date