DEARBORN COUNTY HOSPITAL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

MR Number _____

I, the undersigned, hereby authorize _____ to release information from my (or give relationship) _____ medical record. This authorization includes release of information concerning **HIV testing or treatment or AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.**

PATIENT INFORMATION (Please print)

LAST NAME	FIRST	MIDDLE	MAIDEN (if applicable)

ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH	SOCIAL SECURITY NUMBER	PHONE NUMBER

The following information (but not limited to) may be released or reviewed.

____INPATIENT ____OUTPATIENT ____ EMERGENCY DEPARTMENT RECORD

____ Face Sheet with Final Diagnosis
____ Discharge Summary
____ History & Physical
____ Operative Report
____ Emergency Department Record
____ Consultation Reports (Specify)_____
____ X-Ray Reports, Labs, or other Tests (Specify) _____
____ Other _____

Dates of Treatment/Particular Illness _____

Name and title of the person the above information is to be released to:

_____

Street Address _____

City, State and Zip Code _____

Records may be: ____ Mailed ____ Picked Up ____ Reviewed Only

Purpose for release of Information: ____ Medical Care ____ Insurance ____ Attorney/Legal ____ Disability/SSI ____ Personal ____ Other (Specify) _____

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to obtain treatment. I understand that this information may be subject to redisclosure by the recipient and will no longer be protected by Federal Privacy Regulations. This statement must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. Please send a written notice of revocation to the Hospital's Privacy Official at 600 Wilson Creek Road, Lawrenceburg, IN 47025. This authorization will expire sixty (60) days after the date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

Signature of Patient or Legal Guardian	Relationship	Date

A standard fee has been established for copies of medical records. Please direct any questions to the Correspondence Clerk in the Health Information Management Department at 537-8250. The Department is open Monday through Friday 8:00 a.m. – 4:30 p.m.

600 WILSON CREEK ROAD LAWRENCEBURG, INDIANA 47025-1199 (812)537-1010