Southeastern Indiana Health Organization

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I _____ who resides at _____

in the city of _____ in the state of _____ hereby authorize:

Name: Southeastern Indiana Health Organization

(PHYSICIAN, HOSPITAL, CLINIC, LAB, REDIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: 417 Washington Street

City, St., ZIP: Columbus, Indiana, 47201

to disclose the following specific medical information by ☐ mail or ☐ fax or ☐ e-mail or ☐ phone to:

Name: _____

Address: _____

City, St., ZIP: _____

Relationship to member: _____

from the Health Records of:

Name: _____

(NAME OF INDIVIDUAL WHOSE HEALTH RECORD IS BEING DISCLOSED)

Address: _____

City, St., ZIP: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments (Explanation of Benefits (EOB), Provider Remittance Advice or similar documents)

_____ Records of visits (all visits)

_____ Record of visit for a specific date or dates Specific dates include or are limited to: _____

_____ Copies of records provided to the above name (i.e. hospital, lab, clinic, etc.)

_____ Progress Notes

_____ Photographs, Videotapes, Digital or other Images

_____ Discharge Summary

_____ History and Physical Examination

_____ Consultation Reports

_____ All of the above

_____ Other (Must be specific) _____

_____ Mental Health and/or Alcohol and Drug Abuse Treatment

_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information

_____ Hepatitis Information

This authorization is given freely with the understanding that:

Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

A photocopy or fax of this authorization is as valid as this original.

I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing. A revocation form is available from the receptionist.

Southeastern Indiana Health Organization, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

PATIENT'S NAME PRINTED

DATE

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

MEMBER ID NUMBER

PATIENT'S PERSONAL REPRESENTATIVE

DATE

PATIENT'S PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT

WITNESS