

**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, RADIOLOGY 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

\_\_\_\_\_ 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.

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PATIENT'S NAME PRINTED

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DATE

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

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SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

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MEMBER ID NUMBER

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PATIENT'S PERSONAL REPRESENTATIVE

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DATE

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PATIENT'S PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT

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WITNESS