MONROE HOSPITAL | Caring For Our Community

MAMMOGRAPHY RELEASE

Monroe Hospital
4011 S. Monroe Medical Park Blvd
Bloomington IN 47403
Phone # 812-825-0792
Imaging Fax: 812-825-0787

Information Request-Authorization for Release of Protected Health Information Regarding Mammography

Patient Name:_____ Date of Birth: ____/____/____ Phone: (____)_____-_____

Address:_____ City:_____ State:_____ Zip Code:_____

I request my medical information from:

Where was you last mammography done _____

Address:_____ City, State, Zip Code:_____

I authorize the following information to be released from my medical record:
Date(s) of Service: _____

The date of service cannot be beyond the date of signature on this authorization

○ Pathology Report ○ Film/Tracing/Media
○ History & Physical ○ Radiology Report
○ Consultation Report ○ Other:_____

Reason for requesting information:
○ Continuation of Care

Release this medical information to: MONROE HOSPITAL
4011 S. MONROE MEDICAL PARK BLVD
BLOOMINGTON IN 47403

****Information maintained in your medical record may include drug testing, HIV and AIDS, and/or psychiatric information.****

Patient Signature:_____ Date:_____

*Authorized Representative:_____ Date:_____

Witness Signature:_____ Date:_____

If signed by a patient's authorized representative: (attach supporting documentation for authorized representative)

Printed name of authorized representative:_____ Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip Code:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in a response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____ (not to exceed 12 months). If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days from the date signed. I understand that authorizing disclosure of my PHI is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my PHI, I can contact the authorized individual or organization making disclosure.
This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical information is ***NOT*** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.