

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide *all* information requested may invalidate this Authorization.

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

**USE AND DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize \_\_\_\_\_

to release to: \_\_\_\_\_ **Covering the period** of healthcare from \_\_\_\_\_ to \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

Email (Secure): \_\_\_\_\_

(Persons/Organizations authorized to receive the information) (Address - street, city, state, zip code)

The following information:

a.  All health information pertaining to my medical history, mental or physical condition and treatment received. - **OR**

Only the following records or types of health information (including any dates):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Consultation(s)  | <input type="checkbox"/> All pertinent Lab / X-rays / EKG |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Other: _____                     |
| <input type="checkbox"/> Rehab                | <input type="checkbox"/> ER               |   |

b. I specifically authorize release of the following information (initial as appropriate):

- |   |                           |
|---|---------------------------|
| _____ Mental health treatment information | _____ STD                 |
| _____ HIV test results                    | _____ Sexual Assault      |
| _____ Alcohol/drug treatment information  | _____ Child Abuse/Neglect |
| _____ Outpatient psychotherapy notes      |                           |

**PURPOSE**

Purpose of requested use or disclosure:  patient request; **OR**  other:

**EXPIRATION**

This authorization expires on: \_\_\_\_\_

**PLEASE CONTINUE ON NEXT PAGE** →



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PATIENT ID

**MY RIGHTS**

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to:

Monroe Hospital  
ATTN: Medical Records  
4011 S. Monroe Medical Park Blvd  
Bloomington, IN 47403

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by Indiana law and may no longer be protected by federal confidentiality law (HIPAA). However, Indiana law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Options of Electronic Format: According to HITECH section 13405(e) (1); 42 U.S.C. 17935 (e) (1), you may have your electronic medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be delivered in and note the receiving entity may not accept records in electronic format:  Burn to CD  Paper  Email

**SIGNATURE**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Signature: \_\_\_\_\_  
*(patient/representative/spouse/financially responsible party)*

If signed by someone other than the patient, state your legal relationship to the patient. Licensed Psychotherapist's approval for geropsychiatric patient:

\_\_\_\_\_

Witness: \_\_\_\_\_



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PATIENT ID