



Authorization To Release Protected Health Information



Name of patient: _____

Street address: _____ City: _____ State: _____ Zip: _____

Telephone number: _____ Birthdate: _____ SS#: _____

Release from:

St. Vincent Evansville
3700 Washington Avenue
Evansville, IN 47750
(812) 485-4000
FAX (812) 485-7609

Physician's Office: _____
Address: _____
City: _____ State: _____ Zip: _____
Fax: _____ Telephone: _____

Release to (Person or Class of persons authorized to receive my Protected Health Information):

(Name) _____ (Fax) _____

(Address) _____ (Telephone) _____

Reason for release:

- Continuing medical care
- Claim for reimbursement
- Litigation against third party other than the hospital, a hospital employee or physician
- Litigation against the hospital, a hospital employee or physician (specify person): _____
- At the request of the Patient or the Patient's Representative
- Other: _____

Specified information to be released:

Dates of treatment: _____ Type of treatment: Inpatient Emergency room Outpatient

- Face Sheet
- History & Physical
- Discharge Summary
- Other (specify): _____
- Consultation Report
- Operative Report
- Pathology Report
- Emergency Room Report
- Laboratory Reports
- X-ray Reports

Authorization:

I understand that the information disclosed may contain testing or treatment information relating to Mental Health; Drug and/or Alcohol Abuse Treatment; Sexually Transmitted Diseases; HIV/AIDS virus.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulation.

I understand that this form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Health Information Management Department.

I understand that refusal to sign this authorization does not condition treatment.

I understand that this authorization will expire sixty (60) days from the date signed unless otherwise specified.

Date, event or condition on which authorization will expire if other than 60 days: _____

Signature of Patient: _____ Date Signed: _____

Signature of Other Authorized Person* _____ Relationship to Patient or Authority to Act for Patient: _____

Signature of Witness: _____ Date Signed: _____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with Ciox to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

Authorization must be signed by the parent or legal guardian of any patient under 18; the legal guardian of any patient under guardianship; the personal representative of a deceased patient, or if no personal representative, the spouse, any adult child of a deceased patient (Chapter 8 of 1.C 16-4, Acts of 1982). If patient is under 18, records are protected by Federal Law (42 CRF, part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian.

