ST. VINCENT WARRICK
1116 MILLIS AVE
BOONVILLE IN 47601
812-897-4800

Authorization To Release Protected Health Information

Name of patient: ____________________

Street address: ____________________ City: ____________ State: ______ Zip: ________

Telephone number: ________________ Birthdate: ____________ SS#: ________________

Release from:

St. Vincent Warrick Hospital
1116 Millis Avenue
Boonville, IN 47601
Fax 812-897-7116

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

(Name) ____________________

(Address) ____________________

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.