INDIANA (HIPAA) MEDICAL RECORDS RELEASE

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name			Date of Birth	**Last 4 digits** of Social Security Number
Address	City	State	Zip Code	Telephone No. E-mail Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information:

Agency or Individual(s) Authorized to Receive my Health Information:

Name:_____ Telephone No:_____
Address:_____ Fax No:_____

Health Information that may be used / disclosed is limited to the following:
☐ Itemized bill ☐ Progress Notes ☐ Pathology Reports
☐ Lab results/reports ☐ Operative/Procedure Reports
☐ Imaging/X-ray reports ☐ Entire Record ☐ Other _____

Health Information that may be used / disclosed is limited to the following Periods of Healthcare:
From: (date): _____ to (date)_____
From: (date): _____ to (date)_____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s) (include Research or Marketing, if appropriate): ☐ Treatment or Consultation ☐ At the Request of Patient ☐ At the Request of the Employer ☐ Billing or Claims Payment ☐ Research ☐ Marketing ☐ Other (specify) _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

I agree to the release of my medical or billing records containing the sensitive information listed above. ☐ ***Yes*** ☐ ***No***

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage. NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature**	Date
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if utilized
Witness's Signature	Expiration Date or Event

There will be a copying charge as set forth in Indiana Code 16-39-9-3.

☐ ***Signature must be validated against driver's license or signature in Medical Record.*

☐ Patient to Pick up ☐ Paper Copy ☐ Mail Documents to Patient ☐ Electronic Copy