AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Harrison County Hospital
1141 Hospital Drive NW
Corydon, Indiana 47112

Name of Patient:	**Social Security Number:**	**Address of Patient:** Street _____ City _____ State _____ Zip

Telephone Number: ( )	**Birthdate:**	**Age:**	

AUTHORIZATION IS GIVEN BY THE UNDERSIGNED TO RELEASE THE INFORMATION SPECIFIED BELOW:

FROM	Name of Organization or Person to RELEASE information: **Harrison County Hospital** _____ Street _____ City _____ State _____ Zip _____
TO	Name of Organization or Person to RECEIVE information: _____ Street _____ City _____ State _____ Zip _____

THE INFORMATION IS REQUESTED FOR THE FOLLOWING PURPOSE:

- ❑ Continuing medical care
- ❑ Claim for reimbursement
- ❑ Litigation against third party other than Harrison County Hospital, or a Harrison County Hospital employee or physician
- ❑ Litigation against Harrison County Hospital or a Harrison County Hospital employee or physician (*Specify*) _____
- ❑ At the patient's request_____
- ❑ Other (*Specify* _____

I understand that this Authorization can be revoked by me at any time by submitting a written request to _____
I understand that revocation will not apply if Harrison County Hospital has already released my information.
I understand that Harrison County Hospital cannot require me to sign this Authorization as a condition for providing treatment of obtaining payment for same.
I understand that the material released as a result of this Authorization may be subject to redisclosure and no longer protected by the laws applying to medical information release.
This Authorization will expire as follows: _____

INFORMATION TO BE RELEASED

Dates of treatment:	Type of treatment: ❑ Inpatient ❑ Emergency Room ❑ Outpatient

- ❑ Fact Sheet
- ❑ History & Physical
- ❑ Discharge Summary
- ❑ Consultation Report
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Emergency Room Report
- ❑ Entire Record

- ❑ X-ray Reports (*Specify type or all*) _____
- ❑ Laboratory Reports (*Specify type or all)* _____
- ❑ HIV Results
- ❑ Other (*Specify*) _____

❑ Check here to request the information in electronic format (applies only to information we maintain in an electronic health record).

_____ _____
(Signature of Patient) (Date Signed)

_____ _____
(Signature of Other Authorized Person) (Relationship to Patient)

This 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 or adult child of a deceased patient. If patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, this Authorization must be signed by both the patient and parent or legal guardian. Emancipated minors may sign for self.

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