La Porte Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION: Name: ______________________ Date of Birth: _____/_____/_____

Address: ______________________ City: ______________ State: ______ Zip: ________

AUTHORIZATION: I authorize **Indiana University Health** and its medical staff and representatives to disclose the following information contained in their medical records to the following Person/Entity: ______________________

Address: ______________________ City: ______________ State: ______ Zip: ________

< OR > **IU Health** may obtain my records from the following Physician/Health Care Facility: ______________________

INFORMATION TO BE RELEASED: **DATE(S) OF SERVICE:** **From:** _____/_____/_____ **To:** _____/_____/_____

☐ Emergency Room Record	☐ Laboratory Reports	☐ EEG, EKG	☐ Immunization Record
☐ Discharge Summary	☐ Radiology Report (x-ray)	☐ Outpatient Therapy	☐ **Entire Record *(copy fees may be large)***
☐ History & Physical Report	☐ Radiology Film(s)	☐ Progress Notes	☐ **View Records Only**
☐ Operative Report	☐ Pathology Report	☐ Consultation Report	☐ **Prefer records in electronic format (CD)**

☐ Other (specify): ______________________

PURPOSE: ☐ **Treatment** ☐ **Self** ☐ **Insurance** ☐ **Legal** ☐ **Other (explain):** ______________________

I understand the information in my health record may include information relating to mental health/drug, alcohol treatment and/or HIV, AIDS, or communicable disease. Unless initialed here, these records will be released with my health record. __________

I understand I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization. This Authorization shall remain valid until it is revoked or it expires. THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED UNLESS A SHORTER TIME PERIOD IS SPECIFIED: ______________________

I understand I am not required to sign this Authorization in order to receive health care treatment. I understand I may inspect or copy the information to be disclosed, as provided in federal law 42 CFR 164.524. Information used or disclosed because of this authorization may be further disclosed by the recipient and not protected by federal confidentiality rules. I agree to pay the cost incurred in copying the medical records set forth by Indiana Code 16-39-9-3.

The signature of a parent (including a non-custodial parent provided there are no court-ordered restrictions) or legal guardian is required for any patient under the age of 18 who is not emancipated. A parent, guardian or custodian may sign for an incompetent patient. The personal representative of the estate may sign for a deceased patient; if no personal representative, the spouse may sign for a deceased patient; if no spouse or personal representative, an adult child may sign for the deceased patient.

SIGNATURE PATIENT/AUTHORIZED PERSON: ______________________ **DATE:** _____/_____/_____

RELATIONSHIP TO PATIENT (if not signed by patient): ______________________ **PHONE:** ______________________

COPY FEE FOR PATIENT RECORDS

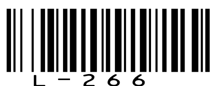
First 1-10 pages ($1/page)	$10.00	Expedited– 2 days	$10.00
Per page 11-50	$ .50	Med. Records CD	$20.00
Each additional page (50+)	$ .25	Radiology CD	$25.00
Certified Record	$20.00		

COMPLETED BY IU HEALTH: MRN:__________ Pages:______

Date:_____/_____/_____ Office Ph#:______________

Initials:______ Photo ID/Signature Verified (if not admitted):______

☐ **COURTSEY** ☐ **MEDICAID** ☐ **PAPER** ☐ **EMR** ☐ **HYBRID**



8/20/13

Patient Label

La Porte Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Instructions for Completing Authorization for Release of Medical Records

To authorize the hospital or physician to OBTAIN medical records from another facility: Check the box near the top and write the name of the facility or physician only if authorizing IU Health to ***OBTAIN*** medical records from ***another*** facility or physician.

PATIENT INFORMATION: Complete name of the patient whose medical records are to be released, date of birth, and complete mailing address.

INFORMATION TO BE RELEASED: Check the minimum information needed to achieve the purpose. Indicate the dates of service (period of time) for which the records are needed. Identify the hospital and/or physician who treated the patient, if known.

TO BE RELEASED TO: Please list the full name and address of the person you are releasing the information to. If the records are being released to yourself, you may write "self" on the name line. OR, if you wish to receive your records in an electronic format (CD) instead, check the box to indicate this.

FOR THE PURPOSE OF: State the reason for requesting the records, such as continued care (appointment with another physician or health care provider), self (for your personal use), insurance claim, legal purposes, or another reason for the request. Please explain.

SIGNATURE AND DATE: Sign and date the form on the appropriate lines. If a parent or guardian, include relationship to patient (such as mother, father, etc.)

Please note the statement that the authorization will expire in 60 days unless otherwise specified. Enter a date when authorization expires if you wish to reduce the automatic expiration date.