Powers HEALTH℠

Authorization for Release of Patient Identifiable Health Information

I authorize the following PH facility(s): ❑ Community Hospital ❑ St. Catherine Hospital ❑ St. Mary Medical Center

❑ Powers Health Rehabilitation Center ❑ MyChart ❑ Joint & Spine Center ❑ Powers Health Medical Group Provider: _____

To release information from the record of:

Patient Name		Phone Number	
Address		Date of Birth	
City, State, Zip Code		Social Security Number (last 4 digits only)	

This information is to be released to the following individual or organization:

Name of Person or Facility			
Address			
Phone Number		Fax Number	

Records are Requested for the Purpose of: ❑ Continuing Care ❑ Insurance ❑ Legal Use ❑ Personal Use

Requested Format: ❑ Electronic ❑ Paper ❑ CD ❑ MyChart

The information I authorize disclosed is: From (date) _____ to (date) _____

- ❑ Abstract of Medical Records
- ❑ Entire Medical Record
- ❑ Discharge Summary
- ❑ History and Physical
- ❑ Consultation Report
- ❑ Operative Report
- ❑ Emergency Record
- ❑ Laboratory Reports
- ❑ Nuclear Medicine Reports/Films
- ❑ Pathology Reports/Slides
- ❑ Radiology (i.e., x-ray)/Imaging Reports/Films
- ❑ Billing: Itemized Statement (800-210-9776)
- ❑ Photographs, Videotapes, Digital, and Other
- ❑ Other: _____

I understand:

- My health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or reproductive healthcare information. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management (HIM) Department. The revocation will not apply to information already released in response to this authorization, and it will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days.
- Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I may inspect or copy the information to be used or disclosed. Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
- There may be a fee for copying these records.
- If I have questions about the disclosure of my health information, I can contact the HIM Department at (219) 392-7164.

I authorize _____ to pick up the requested copies of my record and understand that he/she must be able to prove their identity with a valid driver's license or state identification card.

_____ _____ _____

Signature of Patient or Legal Representative *Date* *Time*

Legal Representative: ❑ Parent ❑ Power of Attorney ❑ Legal Guardian ❑ Executor/Administrator/Personal Representative of Estate *Paperwork Must Be Provided*

If the patient is deceased and there is no documentation of a Personal Representative of the Estate:

❑ I attest there is no Executor/Administrator/Personal Representative of the Estate and that I am the decedent's spouse.

❑ I attest there is no Executor/Administrator/Personal Representative of the Estate or a spouse and that I am the decedent's child.

❑ Other, please explain: _____

❑ I acknowledge that the records I am receiving are **incomplete**. Please initial: _____