Decatur County Memorial Hospital
The Quality Care You Want. Close By.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name _____ Previous Name(s) _____

Patient's Address _____ City _____ State _____

Patient's Date of Birth _____ Social Security # _____

The undersigned hereby authorizes:

☐ Decatur Co. Memorial Hospital
720 North Lincoln St
Greensburg, IN 47240

☐ Provider: Please specify _____
Street _____
City _____ State____ Zip_____

To release or obtain the following portions of the protected health information on the above named patient:

___ Medical Record - period of _____ Area of Concern: _____

___ Specific portions of the medical record: ☐ H&P ☐ DS ☐ OP Report ☐ Lab ☐ X-Ray ☐ EKG ☐ ER

☐ Other _____ for the period of _____

___ Billing Record - period of _____ Disclosure Accounting _____

Release this information to / obtain from:

_____
Name of Person or Institution

_____
Address of Person or Institution

The medical record is used/disclosed for the following purpose: ☐ Medical Care ☐ Personal Use

☐ Other _____
(State the general purpose or intended use of the health information)

☐ I would like to have my medical record provided to me electronically, via email.
Email Address _____ Initials _____

I understand:

- I may **REVOKE** this release at any time, in writing, but the request shall remain valid until revoked, upon the expiration of sixty (60) days, or _____ (expiration date), or _____ (specified event) whichever occurs first, **EXCEPT** to the extent that action has been taken thereon or the Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.
- This release may include medical records of treatment for physical and/or emotional illness (except psychotherapy notes), including treatment of alcohol or drug abuse.
- HIV, AIDS, or AIDS - related information may also be released.
- Once this information has been disclosed there is a potential for the protected health information to be redisclosed by the recipient and no longer protected by law.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.

I acknowledge that I have read and understand this Authorization. Further I authorize the disclosure of my Protected Heath Information in accordance with the terms in the Authorization.

_____ _____
Signature (Patient) Date

_____
Printed

Released by _____

_____ _____
Signature (Authorized Representative) Date

Description of Authorized Representative's authority to sign for patient _____

Date: _____

MR # _____ Acct. # _____

White - Medical Record Yellow - Patient