MEMORIAL MEDICAL GROUP
AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

NAME	TELEPHONE		PREVIOUS NAME, IF DIFFERENT
ADDRESS	BIRTH DATE		SS#
CITY	STATE	ZIP	DATE OR DATES OF SERVICES

1. Facility authorized to release information:

Name: ____

Address: ____

(City) (State) (Zip) ______________

2. Person(s) or Facility authorized to receive the information:

Name: ____

Address: ____

(City) (State) (Zip) ______________

3. Description of information that may be used and disclosed:

	Entire Chart or as specified		Laboratory Report(s)		HIV, Aids, or AIDS related
	Face Sheet		Immunization(s)		Drug and/or Alcohol Abuse
	Discharge Summary		Radiology Report(s)		Mental Health
	History & Physical		Operative Report(s)		Other____________________________
	Consultant Report(s)		Financial		________________________________

3a. **I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information.**

	Patient must initial

4. The information will be used and disclosed for the following purposes:

	Transfer of Care		Insurance		Attorney/Legal		Other:__________________________

5. I understand that the Health information described above may be disclosed by the recipient and the information may no longer be protected by federal privacy regulations.

6. I understand that Memorial Health System, Inc. may receive compensation for the use and disclosure of the information.

7. I understand that Memorial Health System, Inc. will not condition my ability to obtain treatment on the provision of this Authorization.

8. I understand that I may revoke this Authorization in writing at any time by writing to Records Supervisor at Memorial Medical Group unless action has been taken in reliance upon this Authorization. This authorization expires 60 days from the date it is signed by me or unless specified otherwise. I understand there is a charge for copying medical records, $20.00 for single ($35.00 for family) for transfer of care. If this is for an attorney, personal use, or insurance, the charges will be per Indiana code I.C. 16-39-9. These charges do not apply for copies requested for continuing medical care with the Memorial Health System. By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Health Information in accordance with the terms of this Authorization.

____ Signature of Patient, Guardian or Legal Representative

______________________________ Date Signed

______________________ Patient's Name (please print)

______________________ Printed Name of Personal Representative

______________________ Relationship to Patient

______________________________ Witness

☐ Patient was given a copy of this Authorization

______________________________ Released by:

______________________________ Authorization Expiration

Office use only: Delivery Method:____