ESKENAZI HEALTH
720 Eskenazi Ave., Indianapolis, Indiana

Rev. 1/24

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION PAGE 1 OF 1

Type of Request

☐ Copies of the information ☐ Onsite review of information ☐ Verbal release permitting staff to discuss care

Client/Patient Information

Print Name _____ (Last, First, MI) Date of Birth _____ (MM/DD/YYYY) Phone Number _____ Last 4 digits SS _____

Address _____ (Street) (City) (State) (ZIP)

Healthcare Location/Provider (Who has the information you want released)

☐ **Eskenazi Health (includes Sandra Eskenazi Mental Health Center)** ☐ Other – Please indicate below:

Name _____ Phone Number _____ Fax Number _____

Address _____ (Street) (City) (State) (ZIP)

Receiving Party (Who may receive the information/where do you want it sent)

Name _____ Phone Number _____ Fax Number _____

Address _____ (Street) (City) (State) (ZIP)

Information to be Released (What do you want sent or released? Check the appropriate box.)

Date of Service from _____ through _____

☐ Billing Records
☐ Center of Hope
☐ Communicable Diseases *(includes HIV/AIDS status and treatment)*
☐ Discharge Summary/Notes
☐ Consultation
☐ Emergency Records
☐ Films/Images
☐ Forensic Photos
☐ Genetic Testing
☐ History and Physical Report
☐ Immunization/Allergy Records
☐ Laboratory/Pathology Report
☐ Medication Report
☐ Mental Health Records
☐ Progress Notes/Clinic
☐ Operative Report(s)
☐ Radiology Report (X-ray/CT scan/MRI)
☐ Rehab Notes (PT, OT, SLP)
☐ Substance Use Disorder Records ("SUD") *(such as alcohol/drug use abuse, referral, and treatment)*
☐ Exclusions to the medical record (e.g., SUD, mental health)
☐ Other *(specify)* _____

☐ Entire Medical Record (Defined as the designated record set by Eskenazi Health). Includes **EVERYTHING** above: all demographic information, admission and discharge dates, test results/reports, orders, flowsheets, all treatment notes/reports, photos/images, billing records, communicable disease records (including HIV/AIDS status and treatment, mental health records, and **all** substance use disorder (specifically, alcohol and drug abuse diagnosis, referral and treatment) records.

Release Instructions

Your protected health information will be provided to you in **.pdf** file format unless specified below.

Select the method/format: ☐ My Chart ☐ Paper ☐ Fax Number _____ ☐ DVD ☐ USB
☐ Email address _____ ☐ Other format requested _____

Electronic records are delivered in a secure/encrypted method. However, I have a choice to receive my records in an unsecure/unencrypted format.
_____ By initialing here, I understand that unencrypted e-mail **or** media (such as CD, DVD, USB flash drive etc.) is not considered a confidential means of communication.
I have been offered a secure method to receive my records and I have chosen to receive without the protection of encryption. I agree to waive any rights that I may have against Eskenazi Health, any affiliated organization, or physician, or the suppliers, for any compromised information due to the technical failures and/or unintended breach of confidentiality.

Purpose of Request (Why is it needed?)

☐ Continuation of Care/Transfer of Care ☐ Insurance Eligibility/Billing* ☐ Legal/Litigation* ☐ Personal Use/Request of the Individual* ☐ Attorney
☐ Other _____ *Fees may be charged in accordance with Federal Rule 45 C.F.R. §164.524 and Indiana law.

By signing this authorization form, I understand that:

Unless I have limited above, this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, enrollment, billing and other related services which may include information for behavior and mental health treatment and/or counseling, substance use disorder (such as alcohol and/or drug abuse diagnosis, referral, and treatment), communicable disease documentation, Acquired Immunodeficiency Syndrome (AIDS), human immunodeficiency virus (HIV), genetics, and sexual assault.

A fee may be charged for preparing a copy of and/or access to the requested records.

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. This authorization can be revoked at any time in writing to Eskenazi Health except if disclosure is made in good faith and has already occurred in reliance on this authorization.

Eskenazi Health will not condition treatment, payment enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. By signing this authorization, I release Eskenazi Health from any and all liability resulting from a re-disclosure by the recipient.

My signature indicates that I read and understand this form and authorize release of my information as described above.

_____
Date

If patient is unable to sign, secure consent of legal representative and indicate reason. Proof of designation must be filed in record or sent along with request.

_____
Signature of Patient

_____
Signature of Legal Representative and Relationship to Patient

_____
Reason Signed for Patient

_____
Signature of Witness

Department Use Only

Released by _____

_____

Date _____


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White – Individual/Entity to Release Information Yellow – Patient CON-79

Release of Information
Form# EH200075