801 N. State Street
Greenfield, IN 46140
P: (317) 468-4407 F: (317) 468-4309

M/C#_____

V/S#_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/IMAGES ↑AFFIX MEDICAL RECORD/ACCOUNT NUMBER LABEL HERE.

Patient's Name _____ Patient's Date of Birth _____

Patient's Address _____ Patient's Telephone Number _____

City _____ State _____ Zip Code _____ XXX-XX-_____ Patient's Social Security Number (Last 4 digits ONLY)

The undersigned hereby authorizes Hancock Regional Hospital and/or Hancock Regional Surgery Center, LLC to release the following portions of the medical records/images of the above named patient:

Records Being Requested From: ☐ Hancock Regional Hospital ☐ Hancock Regional Surgery Center, LLC ☐ Both Facilities

For the period of _____to _____.

☐ Entire Medical Record/All Image(s).

☐ Specific portions of the Medical Record/Image(s) (please describe): _____.

NOTE: RECORDS COULD CONTAIN SENSITIVE INFORMATION, SUCH AS HIV AND STD TESTING, DRUG AND ALCOHOL.

Documents requested, but not provided and reason why: _____.

Please choose medical record/image(s) format: ☐ ***Paper*** ☐ ***CD*** ☐ ***Flashdrive*** ☐ ***Secure Email*** ☐ ***UnSecure Email*** ☐ ***Secure Fax*** ☐ ***Unsecure Fax*** *(Warning*: Unsecure fax and/or unsecure email could potentially have unauthorized viewing of your medical records).

☐ I have read the warnings above and wish to receive my records/images via unsecured email or fax. If I have selected this option, by signing this form below I agree to have my medical records sent via unsecure email and/or unsecure fax.

Release this information to: ☐ Self _____
Name of person or organization

Email Address _____ Address of person or organization City, State, Zip Code _____

Telephone Number and/or Fax Number _____ Provide purpose for request of Medical Record/Image(s) _____

I understand that this information is voluntary and that I have the right to revoke it at any time prior to or upon the **expiration of sixty (60) days**, whichever occurs first, EXCEPT to the extent that action has been taken thereon. This revocation will not have any effect on the information released as a result of the Authorization before the revocation. I understand that the information released may be subject to redisclosure by any recipient and no longer protected by federal privacy laws. The facility(s) will not condition my treatment, payment, enrollment in health plan of eligibility for benefits on my providing authorization for this release except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party. I also understand that faxed and/or photocopies of this release are permissible. I also understand that Hancock Regional Hospital is affiliated with Hancock Regional Surgery Center, LLC through a joint venture. By signing this authorization I am acknowledging that I may request and/or receive protected health information created at either facility. DRUG & ALCOHOL RECORDS ONLY: The information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from taking any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol and drug abuse patient. 42 C.F.R § 2.32.

Patient or Legal Representative Signature _____ Signature Date _____ Relationship (if other than patient) _____

(office use only)

ID Checked By _____ #CD/pages released _____ Request Taken by _____ Date _____

Information Released by _____ Date _____ ☐ IN PERSON ☐ MAIL ☐ EMAIL

☐ FLASHDRIVE ☐ FAXED ☐EMR ASSOCIATE VIEW / ☐ CD ☐ RECORDS ☐ BOTH Consent Expiration Date _____

Origin 2/97 Revision 12/01, Revised 8/05, Revised 3/08, Revised 5/13, Revised 10/14, Revised 9/16; Revised 9/16, REV 7.17
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