ELKHART GENERAL HOSPITAL
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Name	Telephone ( )	Previous admission name, if different
Address		Birthdate
City State Zip		Date(s) of service

By signing below, I hereby authorize my health information, as more specifically described below, to be used or disclosed by Elkhart General Hospital. (This information is referred to as "Protected Health Information").

I hereby authorize: **Elkhart General Hospital**; P.O. Box 1329; Elkhart, IN 46515-1329
(574) 523-3197 (Medical Record Department) (574) 523-3474 (fax – Medical Record Department)

□ To **Release** and disclose my Protected Health Information **to** | □ To **Receive** my Protected Health Information **from**

Name

Address

City State ZIP

This authorization shall remain valid for sixty (60) days from the date of signature. This authorization will expire on: (specific event/date) _____. I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if:

- Elkhart General Hospital has already acted on this authorization;
- Or, if this 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.

I understand that I may revoke this Authorization by submitting my request in writing to the Health Information Management (Medical Records) Department at the above address. I understand that the medical information released may contain information concerning the treatment of physical or emotional illness, drug and/or alcohol abuse, mental health, communicable disease, HIV, AIDS or AIDS related illness.

I understand that my health information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my information will no longer be protected by the Federal Privacy Regulations.

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

I understand that there is a charge for copying medical records at a fee of $1.00 per page for the first ten (10) pages, 50 cents per page for pages 11-50 and 25 cents for pages 51 and higher. These charges do not apply to copies being requested for further medical care.

INFORMATION TO BE RELEASED

□ Partial chart (includes all physician dictation and all results of test(s)	□ History & Physical	□ Radiology Report(s)
□ Entire Chart (all health information)	□ Consultant Report (s)	□ Operative Report(s)
□ Face Sheet	□ Emergency Room Report	□ Other _____
□ Discharge Summary	□ Laboratory Report(s)	_____

REASON FOR DISCLOSURE: This information will be released for the following purpose:

□ Personal Use □ Continuing Patient Care □ Insurance
□ Attorney/Legal □ Other: _____
Delivery Method: □ Mail □ Patient will pick up when ready

SIGNATURE

Signature of Patient:		Date:
Printed:	Witness	
Signature of Parent (if patient is under 18) or Authorized Legal Representative		Date:
Description of Authorized Representative's Authority to Sign for Patient:		

□ Patient was given a copy of this authorization.

Addressograph

Elkhart General

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White - chart
Yellow - patient