Authorization to Receive and Disclose Patient Information

Schneck Primary Care Professional Building 4th Floor
411 W Tipton St., Seymour, IN 47274
Phone: (812) 523-5862
Fax: (812) 523-4753
Email: healthinfo@schneckmed.org

Patient Information (please print):

First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip:
Date of Birth (MM/DD/YY)	Phone:		

Who are you authorizing to receive or disclose your records?

Organization Name: ____ Fax #: ______________________
Address: ____ Phone #:____________________

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ____/____/____ through ____/____/____

- ☐ Discharge Summary
- ☐ Emergency Room Records
- ☐ Progress Notes
- ☐ Operative/Procedure Reports
- ☐ Immunization Record
- ☐ Test Results (X-ray, lab/pathology results) Please Specify:______________________________
- ☐ Other—Please Specify:____

Special authorization: State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained.

- ☐ HIV testing and results
- ☐ Psychotherapy notes
- ☐ Alcohol, drug or substance abuse records
- ☐ Mental Health Records
- ☐ Genetic records

Purpose of release:

- ☐ Continuing care
- ☐ Transfer of care
- ☐ Social Security Appeal
- ☐ Insurance Application*
- ☐ Insurance payment/claim
- ☐ Litigation/legal*
- ☐ Social Security Disability Determination*
- ☐ Other: ____________________

*Fees may be charged in accordance with the IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. § 164.524

Your Rights with respect to this authorization:

I understand I have the right to withdraw this authorization at any time. I understand that if I withdrawal this authorization I must do so in writing and present my written withdrawal to the Health Information Services department of the entity listed above. I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy and will not apply to action taken in reliance upon this authorization. I understand that I will be provided a copy of the signed authorization upon request. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

This authorization will expire 60 days from the date signed unless otherwise specified ________________________

____ ______________

Signature of Patient or Legal Representative **Date**

____

Signature of Witness

Patient is:	☐ Minor	☐ Incompetent	☐ Deceased
Legal Authority:	☐ Parent	☐ Legal Guardian	☐ Executor of Estate

☐ POA for healthcare ☐ Authorized legal representative