All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name | Date of Birth | Medical Record #

Address | Telephone No.

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information | Telephone No.

Address

Agency or Individual(s) Authorized to Receive my Health Information | Address | Telephone Number

Health Information that may be used / disclosed is limited to the following: ☐ Progress Notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History & Physical ☐ Consultation(s) ☐ Lab ☐ Pathology Report
☐ Operative Note(s) ☐ Imaging/X-ray ☐ X-ray Reports ☐ Entire Record ☐ Other, (specify)_____
☐ Continuity of Care Document (CCD)

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health Information to be released to the above named agency/individual is to be used/disclosed for the following purpose(s):
☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing of Claims Payment
☐ At Request of Employer ☐ Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above. ☐Yes ☐No

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature* | Date | Time

Relationship to Patient / Authority to Act on Patient's Behalf | Interpreter, if Utilized

Witness's Signature | Expiration Date or Event

☐ *Signature must be validated against driver's license or signature in Medical Record.*
There may be a charge for copying Medical Records.

☐ Patient to Pick up ☐ Paper Copy ☐ Mail Documents
☐ Mail Documents to Patient ☐ Electronic Copy to New Physician

Lutheran Health Network
St. Joseph Hospital
700 Broadway Fort Wayne IN 46802

Form Number 4200-0008-1L Rev. 06/20/12
PHI-Auth for Use and Disclosure

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/ /
ATT:,
PCP:,
REF:
ALERT:

St Joseph Hospital

Obtaining Copies of your Medical Records Release of Information (ROI)

A patient, or his/her legal representative, may inspect and/or obtain a paper or *electronic copy, or have copies of medical records sent to another facility. There may be a charge for this service. *A memory stick will be provided for those requesting copies in electronic format.

St Joseph Hospital requires a completed and signed written request or authorization form for release of protected health information before releasing any documents to anyone, including the patient.

Records can be released to anyone that the patient authorizes (in writing along with photo ID). A valid authorization MUST be fully completed, dated and signed or the request will be returned.

Forms completed by Power of Attorney (POA) require a copy of POA paperwork.

Medical records may be requested by a competent patient if the patient is 18 years of age or has been emancipated.

Medical records of a deceased patient may be requested by the personal representative of the patient's estate. If the deceased does not have a personal representative, his or her spouse may make the request. If there is no spouse, a child of the deceased patient (or the parent, guardian or custodian of the child if the child is incompetent) may make the request.

If the patient did not die within St Joseph Hosptial, verify death by providing a copy of the death certificate. All requests will be reviewed to determine the identity of the requestor.

Completing Request for Medical Records

- The top section must have the Patient's name, complete address, date of birth and phone number; the medical record number is something you will leave blank.
- The facility authorized to release your health information would be the facility you were treated in; St Joseph Hospital; it is not necessary to complete the address and phone number for facility.
- The agency or individuals authorized to receive my Health Information will be left blank unless you authorize another person to receive your medical records. This form is only for the current request; it will not apply to future requests.
- Please check reports you are requesting.
    - CCD (Continuity of Care Document) is a summary of medications, allergies, adverse reactions, problems, immunizations, last lab and radiology results, procedures performed, consultations, history and physical, and discharge instructions
- There may be a charge for copying medical records.
- Then complete the date(s) you are requesting, if you don't have exact dates you can list month, or even year; account number would be left blank.
- If applicable, check yes or no as it pertains to sensitive information.
- The request will need to be signed, dated and timed at the bottom; the witness's signature line will remain blank.
- Please check whether you prefer to have mailed or you will pick up and what media you prefer.

If you have any questions please call (260) 425-3166 and ask for Release of Information.

Thank you.

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/ / ?
ATT:,
PCP:,
REF:
ALERT: