Place Label Here

Ascension St. Vincent

MRN/MPI # ________________________
ECD # ________________________

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I (the undersigned) hereby authorize the Ascension St. Vincent facility indicated below to disclose the following identified information.

SELECT FROM 1 GROUP BELOW RESPONSIBLE FOR RELEASE OF RECORDS		
Select one or more per form:	**INDY REGION:** **NEIGHBORHOOD ED FACILITES:**	□ Indianapolis □ Peyton Manning □ Women's □ Carmel □ Fishers □ Seton Specialty □ Heart Center □ Williamsport □ Avon □ Castleton □ Indy South □ Noblesville South □ Plainfield
Select one per form:	**HOSPITAL LOCATIONS:**	□ Anderson □ Clay □ Dunn □ Frankfort □ Jennings □ Kokomo □ Mercy □ Randolph □ Salem
Select one or more per form:	**EVANSVILLE REGION:**	□ Evansville □ Warrick □ Ascension Medical Group

PATIENT INFORMATION

Name of Patient	**Date of Birth**	**Phone Number**
Other Names used during treatment (if applicable)		
Address	**City, State, Zip Code**	
Purpose of Disclosure	**Email**	

RELEASE INFORMATION TO IF NOT PATIENT:

Name	
Address	**Phone Number**
City, State, Zip Code	**Email**

INFORMATION TO BE RELEASED (limit request to the minimum necessary)

Dates of Treatment: ________________________________

	PROCEDURE REPORT		REHAB SERVICES		CARDIAC TESTING
	DICTATION		RADIOLOGY REPORTS		ER REPORTS
	ABSTRACT: DICTATION, LABS, RADIOLOGY AND ER REPORTS		LAB AND PATHOLOGY REPORTS		DISCHARGE SUMMARY/ SHORT STAY NOTE
	OTHER: Please Specify				

◦ I understand that the Protected Health Information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
◦ I understand that I have the right to revoke this authorization, in writing. I understand that a revocation is not effective to the extent that Ascension St. Vincent has relied on the use of disclosure of the protected health information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The written revocation must be sent to the attention: HIM Manager, St. Vincent Health, 2001 W. 86th Street, Indianapolis, IN 46260
◦ I understand that this authorization will expire in sixty (60) days and one hundred eighty days (180) for mental health unless otherwise specified here ___________.
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.
◦ Ascension St. Vincent will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
◦ I understand that I am responsible for paying the applicable fees, if any. I have the right to an estimate of the fees before receiving a copy of the records.
◦ 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.

Send by: □ Mail, □ Email, or □ Hold my records for pickup. If nothing is checked, records will be mailed.

Signature of Patient, Guardian, Parent, or Health Representative			**Date Signed**
Relationship to patient (if other than self or your minor child we will require proof of authority to act on behalf of patient)			
FOR INTERNAL USE ONLY			
□ ID or Signature Checked	□ Verbal Confirmation	HIM Signature	Date: