COMMUNITY HEALTHCARE SYSTEM®
COMHS.org

I authorize the following CHS Facility(s): ☐ Community Hospital ☐ St. Catherine Hospital ☐ St. Mary Medical Center

☐ Community Stroke and Rehabilitation Center ☐ Community Care Physician _____

To release information from the record of:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION			
Patient Name		Phone Number	
Address		Date of Birth	
City		Social Security Number	
State, Zip Code			(last 4 digits only)

THIS INFORMATION IS TO BE RELEASED TO THE FOLLOWING INDIVIDUAL OR ORGANIZATION			
Name of Person or Facility			
Address			
Telephone Number		Fax Number	

Records are requested for the purpose of: ☐ Continuing Care ☐ Insurance ☐ Legal ☐ Personal Use
Requested Format: ☐ Paper ☐ Electronic ☐ CD ☐ MyChart

The Information I authorize disclosed is: From (date) _____ to (date) _____.

- ☐ Abstract of medical records
- ☐ History and Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Emergency Record
- ☐ Photographs, Videotapes, Digital & other Images
- ☐ X-ray and Imaging films/Reports
- ☐ Laboratory Report
- ☐ Nuclear Medicine Report/Film
- ☐ Entire Medical Record
- ☐ Pathology Report and Slides
- ☐ Billing: Itemized Statement (800-210-9776)
- ☐ Electronic Copy of Discharge Instructions

☐ Other _____

I understand that my health 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 a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the Health Information Management Department. I understand that the revocation will not apply to information already released in response to this authorization. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Department at (219) 392-7164.
I understand there may be a fee for copying these records.

I authorize _____ to pick up the requested copies of my record and understand that he/she must be able to prove their identity with a valid driver's license or state identification card.

_____ _____
Signature of Patient or Legal Representative Date

Legal Representative ☐ Parent
Paperwork must be provided for: ☐ Power of Attorney ☐ Legal Guardian ☐ Executor/Administrator/Personal Representative of the Estate
If patient is deceased and there is no documentation of a Personal Representative of the Estate:
☐ I attest that there is not an Executor/Personal Representative and I am the spouse of the decedent.
☐ I attest there is not an Executor/Personal Representative or a spouse of the decedent and I am a child of the decedent.
☐ Other (Please explain) _____
☐ I acknowledge that the records I am receiving are **incomplete**, please initial _____.