I authorize the following PH facility(s): ❑ Community Hospital ❑ St. Catherine Hospital ❑ St. Mary Medical Center
❑ Powers Health Rehabilitation Center ❑ MyChart ❑ Powers Medical Group Provider: ____________________

To release information from the record of:

AUTHORIZATION FOR THE 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 Use ❑ Personal Use
Requested Format: ❑ Electronic ❑ Paper ❑ CD ❑ MyChart

The information I authorize disclosed is: From (date) ____________________ to (date) ____________________

❑ Abstract of Medical Records
❑ Entire Medical Record
❑ Discharge Summary
❑ History and Physical
❑ Consultation Report
❑ Operative Report
❑ Emergency Record
❑ Laboratory Reports
❑ Nuclear Medicine Reports/Films
❑ Pathology Reports/Slides
❑ Radiology (i.e., x-ray)/Imaging Reports/Films
❑ Billing: Itemized Statement (800-210-9776)
❑ Photographs, Videotapes, Digital and Other
❑ Other: ____________________

I understand:

- My health record may include information relating to sexually transmitted diseases, 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 have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management (HIM) Department. The revocation will not apply to information already released in response to this authorization, and it 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.
- Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I may inspect or copy the information to be used or disclosed. 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 the disclosure of my health information, I can contact the HIM Department at (219) 392-7164.
- 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* *Time*

Legal Representative: ❑ Parent ❑ Power of Attorney ❑ Legal Guardian ❑ Executor/Administrator/Personal Representative of Estate
Paperwork Must Be Provided

If the patient is deceased and there is no documentation of a Personal Representative of the Estate:
❑ I attest there is no Executor/Administrator/Personal Representative of the Estate and that I am the decedent's spouse.
❑ I attest there is no Executor/Administrator/Personal Representative of the Estate or a spouse and that I am the decedent's child.
❑ Other, please explain: ____________________
❑ I acknowledge that the records I am receiving are **incomplete**. Please initial: ___________