Print Form

Johnson Memorial Hospital
1125 West Jefferson St.
P.O. Box 549
Franklin, IN 46131
(317) 736-3300

REQUEST AND AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I (we), the undersigned, hereby request and authorized access to the indicated Medical Records for review, examination, and provision of such copies as may be requested.

SECTION 1- PATIENT INFORMATION (Please Print)

Patient Name:_____ MR# _____ (in office use only)
Last First Middle

Address:_____ _____
Street Apartment #

_____ _____ _____
City State Zip

DOB: _____ Age:_____ SS# _____ Telephone # _____

SECTION 2- INFORMATION TO BE RELEASED

Date of service for which information is needed:____/____/____ through ____/____/____

☐ Communicable Disease (i.e., HIV, Hepatitis, Venereal disease
☐ Selected portions of the Medical Record
☐ Emergency Room Report ☐ Mental Health
☐ Drug & Alcohol Abuse Records

Access to records pertaining to drug and/or alcohol abuse records by a minor patient requires BOTH minor patient and parent or guardian to sign.

Notes & Treatment Records & Reports:

☐ Admit H & P ☐ Discharge Summary
☐ Nurses Notes ☐ Physical Therapy Notes
☐ Physicians Orders ☐ Occupational Therapy Notes
☐ Operative Report ☐ Telemetry Reports
☐ Speech Therapy Notes ☐ Discharge Instructions

☐ Other (specify)_____

SECTION 3- PURPOSE OR NEED FOR THE INFORMATION

☐ Court Ordered ☐ Insurance Claim ☐ Review & Audit of Services Rendered ☐ Legal Suit ☐ Patient Request
☐ Continuum of Care ☐ Changing Physicians Other (Specify) _____

Individual/institution Receiving Information:

Name:_____

Address: _____

City/State/Zip: _____ Phone: _____

Individual/institution Releasing Information:

Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

SECTION 4- AUTHORIZED SIGNATURE: I (we) further agree that the hospital may charge me or any designated recipients the actual cost incurred in preparing the copy of the requested Medical Records.

INDICATE PERSON SIGNING BY CHECKING APPROPRIATE RELATIONSHIP

☐ Patient ☐ Parent/Guardian of Minor Patient ☐ Guardian of incompetent patient ☐ Spouse
Deceased Patient's: ☐ Personal Representative, if none, ☐ Spouse; if none ☐ Any adult child of the deceased patient

Signature-_____ Date:_____

Address: _____ Phone:_____

Witness: _____ Date:_____

Records released by: ☐ Paper ☐ Thumb Drive ☐ CD ROM

Generally speaking, the Hospital may not condition treatment, payment, enrollment or eligibility for benefits on the provision of this authorization, but there are exceptions to this. I (we) understand that the information disclosed pursuant to this authorization may be subject to redisclosure.

It is understood that this request and authorization may be revoked by me (us) at any time in writing except to the extent that action has been taken in reliance thereon. It is also understood that this consent will expire 60 days, from the date signed, if not previously revoked, or upon the subsequently specified date, event or condition:

REVOCATION DATE:_____

Please see Fee Schedule on Back

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Fee Schedule

Identification	Price
Pages 1-10	$1.00 Per Page
Pages 11 - 50	$ .50 Per Page
Pages 51 & Greater	$ .25 Per Page
Records on Demand	$10.00
Records Within 2 Days	$10.00
Certified Records	$20.00
Basic Fee *	$20.00
CD's of Record	$2.50 per CD