



(To Be Completed by JMH Staff)

MRN#: _____
FIN#: _____

REQUEST AND AUTHORIZATION TO OBTAIN AND/OR RELEASE MEDICAL INFORMATION

I, the undersigned, hereby request and authorize disclosure of the indicated Medical Records from the following facility. (Please check box)
Johnson Memorial Health (hospital and/or hospital outpatient clinics):

- Hospital Breast Center Immediate Care Pain Relief Specialists Occupational Health Oncology Wound Healing

Johnson Memorial Health Physician Network (JMH physician offices):

- Family Practice Internal Medicine Orthopedic Surgery/Sports Medicine Pediatrics Pulmonology Surgical Specialists Women's OB/GYN

Obtain / Release Medical Records From - Facility Name: _____ PH#: _____
Address: _____ City/State/Zip: _____ FAX#: _____

SECTION 1 - PATIENT INFORMATION (Please Print)

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Telephone Number: _____ Alternate Telephone Number: _____

SECTION 2 - INFORMATION TO BE RELEASED Date(s) of service to be released from: ____/____/____ through ____/____/____

- | | | |
|---|---|--|
| <input type="checkbox"/> Pertinent Medical Records (dictations, labs, x-rays) | <input type="checkbox"/> Emergency (ER) Report | <input type="checkbox"/> Itemized Bill |
| <input type="checkbox"/> Physician Office Notes (Dr. _____) | <input type="checkbox"/> Discharge Summary / Instructions | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Rehabilitation / Therapy Records (PT, OT, Speech) | <input type="checkbox"/> Operative (Surgery) Report | <input type="checkbox"/> Paternity Affidavit |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Radiology Images/Films (on a CD) | <input type="checkbox"/> Cardiology |
| <input type="checkbox"/> Facesheet | <input type="checkbox"/> Other: _____ | |

Special Authorization State & Federal Laws protect the following health information.

If your medical record may contain any of the protected health information below, please indicate if you would like to have this data released.

- | | | |
|--|------------------------------|-----------------------------|
| Alcohol, Drug or Substance Abuse Records | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV Test and Results | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mental Health Records | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SECTION 3 - RELEASE INFORMATION TO THE FOLLOWING FACILITY/PERSON Me/Patient (or Legal Representative) Other (see below)

Company / Name: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Ext: _____ Fax Number: _____

SECTION 4 - PURPOSE OF RELEASE

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Personal / Patient Use* | <input type="checkbox"/> Attorney / Legal Request* | <input type="checkbox"/> Insurance* | <input type="checkbox"/> Social Security / Disability* |
| <input type="checkbox"/> Continuing Care / Physician | <input type="checkbox"/> Workman's Comp | <input type="checkbox"/> School / Daycare | <input type="checkbox"/> Other: _____ |

*Fees may be applied in accordance with Indiana Statute 760IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

SECTION 5 - ACKNOWLEDGEMENT AND CONSENT TO RELEASE HEALTH INFORMATION

- This authorization will expire in 60 days from the date signed unless otherwise specified here: _____
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization. Also, if applicable, I understand that JMH may charge for medical record copies.
- I understand that JMH cannot prevent re-disclosure of my information by the person/company who receives my data as directed by this authorization. By signing this authorization, I release JMH from any and all liability resulting from a re-disclosure by the recipient.
- I understand that my JMH record may contain data that was received from another facility & it may be released as part of this request.

Your signature indicates that you have read and understand this form and you authorize release of your JMH medical record as described above.

Patient Signature (or Legal Representative**) Date Time _____ AM/PM

**Relationship to Patient: _____ Provide documentation of authority to act on behalf of Patient.

To Be Completed By JMH Release of Information Staff:

Signature Verified Via: Photo ID _____ Signature on File _____
Initials of Staff Releasing Records: _____ Date: _____