JOHNSON MEMORIAL HEALTH

1125 West Jefferson St. | Franklin, Indiana | 46131

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# ______________
Last First Middle (in office use only)

Address: ______________________ ______________
Street Apartment #

______________ ______________ ______________
City State Zip

DOB: ____________ Age: ____________ ID# ____________ 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.
- ☐ Other (specify) ______________________

Notes & Treatment Records & Reports:

- ☐ Admit H & P
- ☐ Nurses Notes
- ☐ Physicians Orders
- ☐ Operative Report
- ☐ Speech Therapy Notes
- ☐ Radiology
- ☐ Discharge Summary
- ☐ Physical Therapy Notes
- ☐ Occupational Therapy Notes
- ☐ Telemetry Reports
- ☐ Discharge Instructions
- ☐ Labs
- ☐ Images/Films

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 ☐ E-mail ______________

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

Release of Information:
Fax: 317-736-3368
Phone: 317-736-3573
Email: releaseinfo@johnsonmemorial.org