WindRose Health Network
"... leading you to better health"

WHN – EPLER PARKE
5550 South East St
Suite C
Indianapolis, IN 46227
(317) 534-4660

WHN-COUNTYLINE
8921 Southpointe Drive,
Suite A-1
Indianapolis, IN 46227
(317) 884-7820

WHN ADMINISTRATIVE CENTER
911 E. Main Cross St.
Edinburgh, IN 46124
(317) 739-4895

WHN-FRANKLIN
55 N. Milford Drive.
Franklin, IN 46131
(317) 739-4848

WHN-HOPE
163 Butner Drive
Hope, IN 47246
(812) 546-6000

WHN-TRAFALGAR
14 Trafalgar Square
Trafalgar, IN 46181
(317) 412-9190

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize WindRose Health Network to use or disclose copies of the following individually identifiable Protected Health Information (PHI) about me to or for the party or parties listed below:

LOCATION AUTHORIZED TO RELEASE:		**LOCATION AUTHORIZED TO RECEIVE:**	
Location Releasing Information		Location to Receive Information	
Address		Address	
City/State Zip		City/State/Zip	
Phone	Fax	Phone	Fax

This authorization permits WindRose Health Network to use or disclose copies of the following individually identifiable health information:

_____ Contents of entire medical record including information on drug, alcohol, mental health and infectious disease.
_____ Contents but exclude information on drug, alcohol, mental health and infectious disease.
_____ Contents but exclude information from any other doctors, facilities, etc.
_____ Other (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.):_____

For the purpose of:_____

I understand this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. This consent will expire in 60 days.

Indiana Code #16-39-1-1 provides a written request may be made and provided to WindRose Health Network in a specified manner for an appropriate fee. Therefore, I understand and agree that I may be financially responsible for fees associated with my request.

I understand this facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent and authorized herein.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient, and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that Trafalgar Family Health Center has acted in reliance upon this authorization. My written revocation must be submitted to WindRose Health Network's Privacy Officer located at Trafalgar Family Health Center, 14 Trafalgar Square, Trafalgar, IN 46181.

Patient Information & Authorized Signatures

Patient Name (print)		Date of Birth	
Signature Patient/Legal Guardian		Date Signed	
Relationship to Patient		Phone Number	( )
Patient Address		City/State	

PROHIBITION ON REDISCLOSURE: This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR,Part 2) prohibit the recipient from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another parties is NOT sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

( ) Mail **( ) Pick Up** **( ) Fax Action**

Date Completed:_____ **Staff Name:**_____