Med Bill
8646 Castle Park Drive Indianapolis, Indiana 46256

PATIENT PRICING
$20 - Flat Fee
Requires one (1) picture I.D.

10/13

AUTHORIZATION FOR THE RELEASE OF INFORMATION

YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAYBE RETURNED TO YOU TO BE COMPLETED.

1.) Identity:
Patient Name: _____
S.S. Number: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____ Phone #: _____

2.) Type of release: ☐ Paper copies of the information ☐ Onsite review of information ☐ Verbal release permitting staff to discuss care

3.) Sender and receiver: I authorize the release of medical information (as indicated). Please provide complete mailing addresses.

Ambulance Svc _____
_____
(Facility to release information) _____
_____

Release To: _____
☐ By Mail _____
_____
☐ I would like to pick up information. Please call: _____

4.) Timeframe: I would like information from the following dates: _____ through _____.

5.) What to release: Please check the information you would like released

☐ *INPATIENT*
☐ Records related to (specify): _____
☐ Discharge Summary ☐ Operative Report(s)
☐ X-Ray Report ☐ Pathology Report(s)
☐ History & Physical ☐ Laboratory Report(s)
☐ Other (specify): _____

☐ *OUTPATIENT*
☐ Records related to (specify): _____
☐ Clinic Notes ☐ X-Ray Report(s) ☐ Pathology Report(s)
☐ ER Notes ☐ Ambulance Run ☐ Lab Report(s)
☐ Biopsychosocial Assessment ☐ Treatment Plan
☐ Pharmacy ☐ Other (specify): _____

6.) Release for special protected information:
I authorize the release of information pertaining to communicable diseases and drug & alcohol abuse treatment records as protected by 42 CFR Part 2:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS). ☐ YES ☐ NO/NA
b. The diagnosis or treatment of alcohol and/or substance abuse. ☐ YES ☐ NO/NA
c. The treatment and/or consultation for mental health or psychological conditions ☐ YES ☐ NO/NA

Note to recipient of information released under paragraph 6.) b.: This information has been disclosed to you from records protected by federal confidentiality rules - namely 42 CFR Part 2. Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse.

7.) Purpose for the release: Check one ☐ Health Care ☐ Insurance ☐ Legal ☐ Other (specify): _____

8.) Expiration date: This authorization will expire in 60 days unless otherwise indicated or in the following event _____ or condition _____.

- I understand this Authorization can be revoked at any time, verbally or in writing, unless action has been taken in reliance on it.
- Treatment, payment, enrollment in any health plan or eligibility is not conditioned upon signing this Authorization.
- Unless covered by paragraph 6.) above once this information is released, it is not protected by Eskenazi Health and may potentially be redisclosed by the party who receives this information.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of this information.

_____
Date

_____
Signature of Patient

If patient is unable to sign, secure consent of legal representative and indicate reason. Proof of designation must be filed in record or sent along with request.

_____
Signature of Legal Representative and Relationship to Patient

_____
Reason

_____
Signature of Witness

Department Use Only
Released by: _____
_____
Date: _____