

Southern Indiana Rehab Hospital

A partnership of Frasier Rehab Institute, Floyd Memorial Hospital and Health Services, and Clark Memorial Hospital

AUTHORIZATION TO RELEASE INFORMATION

I, _____, born _____ and residing at _____

Name of Patient

Date of Birth

No. Street _____ City _____ Zip Code _____ Telephone _____

authorize Southern Indiana Rehabilitation Hospital, New Albany, IN to release information from my medical record. This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV or AIDS related conditions.

Information to be released:

<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Operative reports (surgery dates) _____	<input type="checkbox"/> X-Ray reports
<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Pathology reports	<input type="checkbox"/> Outpatient record
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Laboratory reports	<input type="checkbox"/> Other (Specify): _____
<input type="checkbox"/> Facesheet	<input type="checkbox"/> Therapy notes	_____
<input type="checkbox"/> Neuropsychological test		_____

The above information is to be released to:

Name & Title of Person _____
 Agency/Hospital _____
 Street Address _____
 City, State, Zip _____

The above information is requested to be released for the following purpose:

Continued medical care Legal claim processing Used in external quality/utilization review
 Personal interest Insurance claim processing Other (Specify) _____

This authorization must be signed and dated, and may be revoked at any time according to Southern Indiana Rehabilitation Hospital's Notice of Privacy Practice except to the extent action has been taken prior to revocation. This consent will expire 180 days after the date below, or sooner by my choice, in which case this consent will expire on _____. I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the medical records to the purpose and extent stated above.

Once these records are release, this information is not protected by Southern Indiana Rehabilitation Hospital and may potentially be redisclosed by the party who received these records.

I release Southern Indiana Rehabilitation Hospital, its employees, agents, directors, officers, and affiliates, from any liability that may be incurred by giving this information to the above – named person agency.

The undersigned acknowledges that there may be a charge for retrieval and copies of medical records.

 Patient Signature
 or

 Date

 Parent, Guardian, Authorized Representative

 Witness

 Relationship to Patient

Proof of guardianship received or on chart

PROHIBITION ON DISCLOSURE: This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibits you (the recipient) from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

First Free Copy Yes No