



**AUTHORIZATION FOR THE USE OR DISCLOSURE
OF PROTECTED MEDICAL INFORMATION**

PATIENT IDENTIFICATION

| PATIENT INFORMATION | | | |
|---------------------|---------------------|---------------------------------------|------|
| NAME | TELEPHONE () | PREVIOUS ADMISSION NAME, IF DIFFERENT | |
| ADDRESS | | BIRTH DATE | MR # |
| CITY/STATE/ZIP | | DATE OR DATES OF SERVICES | |

Person(s) or class of persons authorized to receive the information:

Name: _____
Address: _____
City/State/Zip: _____

Description of information that may be used and disclosed:

- | | |
|---|---|
| <input type="checkbox"/> Entire Chart | <input type="checkbox"/> Laboratory Report(s) |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Radiology Report(s) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report(s) |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Consult Report(s) | |

The information will be used and disclosed for the following purposes:

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Continuing Patient Care | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Other: _____ | |

DELIVERY METHOD: Mail Patient will pick up when ready **Review chart in person**

I understand that the health information described above may be disclosed by the recipient and the information may no longer be protected by federal privacy regulations.

I understand that Memorial Hospital of South Bend may receive compensation for the use and disclosure of the information.

I understand that Memorial Hospital of South Bend will not condition my ability to obtain treatment on the provision of this Authorization.

I understand that I may revoke this Authorization in writing at any time by writing to Records Management Department – Memorial Hospital of South Bend unless action has been taken in reliance upon this Authorization. This Authorization expires 60 days from the date it is signed by me. I understand that the medical information released may contain information concerning treatment of physical and/or emotional illness, drug and/or alcohol abuse, mental health, communicable disease, HIV, AIDS or AIDS-related illness. I understand there is a charge for copying medical records at a fee of \$20.00 up to ten (10) pages and \$.50 for each additional page, plus postage. These charges do not apply for copies requested for continuing medical care. By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my health information in accordance with the terms of this Authorization.

| | |
|--|-------------------------|
| SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE | DATE SIGNED |
| NAME OF GUARDIAN OR LEGAL REPRESENTATIVE | RELATIONSHIP TO PATIENT |

- Check here if you are a Memorial Hospital/Health System employee.**
 Patient was given a copy of this Authorization.

Original - Medical Records Copy - Patient



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