Patient Authorization to Disclose Health Information

DeKalb Memorial Hospital, 1316 E. Seventh St., Auburn, Indiana 46706 (260) 925-4600

Patient Name: ____________________________ Patient Address: ____

Medical Record # ________________________ Date of Birth ________________________________

1. I authorize the use or disclosure of the above named individuals health information, as described below.
2. The following individuals or organizations are authorized to make the disclosure: DeKalb Memorial Hospital, 1316 E. Seventh St., Auburn, IN 46706.
3. The type and amount of information to be used or disclosed is as follows:
   - ❑ Entire medical record for most recent treatment or hospitalization(s): ____(dates)
   - ❑ The following specific portions of the medical record from the most recent treatment, or ____
   - ❑ Medical records for prior hospitalization only, from _______________ to _______________
   - ❑ Other ____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to, and used by, the following individuals or organizations:
   Name RECORDS DEPOSITION SERVICE, INC.
   Address PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248.357.3330 F: 248.357.3337
6. This information is being disclosed for the following purpose(s): FOR DISCOVERY BEFORE TRIAL
   ____
7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer in the Medical Records Department at DeKalb Memorial Hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
   ____
   (If I fail to specify an expiration date, event, or condition, this authorization will expire sixty days from the date of signing.)
9. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
10. I understand that I need not sign this form in order to ensure health care treatment, payment, or enrollment in my health plan, or eligibility for benefits except that the organization may condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third-party.
11. I understand that I will be given a copy of this authorization form if the hospital initiated the use or disclosure to be authorized.

______________________________________ ____________________

Signature of Patient or Personal Representative Date

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If signed by Personal Representative, relationship to patient

______________________________________ ____________________

Signature of Staff Member Date