1. I authorize Howard Regional Health System to release the **protected health information (PHI)** in its possession concerning:

PATIENT NAME ______________________ **SOCIAL SECURITY NUMBER** ______________

ADDRESS ______________________ **CITY** __________ **STATE** ______ **ZIP** ______

DATE OF BIRTH ______________________ **TELEPHONE NUMBER** ______________

2. **Please specify treatment dates** and check the appropriate box of the type of PHI to be released.

Treatment dates ______ ______ ______ ______ or ☐ All treatment dates with HRHS

☐ History and Physical	☐ Emergency Department
☐ Consultation Reports	☐ Discharge Summary
☐ Surgery Reports	☐ Cardiac Test Results/EEG Results
☐ Radiology / Imaging Reports	☐ Laboratory Results
☐ Behavioral Health	☐ Other______________

3. Send or release the PHI to:

NAME RECORDS DEPOSITION SERVICE, INC. **TELEPHONE NUMBER** P: 248.357.3330 F: 248.357.3337

ADDRESS PO BOX 5054 **CITY** SOUTHFIELD **STATE** MI **ZIP** 48086 - 5054

4. I am releasing the PHI for:

☐ Treatment	☐ Disability
☐ School collaboration	☒ Litigation
☐ Insurance	☐ Other______________

5. I understand that the PHI may include information relating to infectious/communicable diseases and treatment for alcohol and/or drug abuse. It may also mention previous mental health diagnoses or treatments. I also understand any records generated by specific Behavioral Health visits and treatment will not be released unless the Behavioral Health box is checked on this release form. I further understand that I must sign an *Authorization for Release of AIDS/HIV Records* for the release of specific testing results or AIDS/HIV treatment records.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization or to the extent that someone has already acted in reliance on 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. Unless otherwise revoked, this authorization will expire sixty (60) days from the date this authorization is signed. I understand that there is a fee for copies of the medical records and pre-payment may be required. The fees are $20.00 for the first 1-10 pages, .50 per page for pages 11-50, and .25 for pages 51 and higher. I also understand that an additional fee, as allowed under Indiana law, will be charged for all expedited requests.

7. I understand that authorizing the obtaining/disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment for treatment, or eligibility or enrollment in health benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules after it is released. If I have questions about obtaining / disclosure of my health information, I can contact the **Health Information Services Department at (765) 453-8423.**

______________________ ______ ______________________
Signature of Patient or Legal Representative **Date** **If Legal Representative signs, state relationship to Patient**

______________________ ______
Witness Verifying Signature **Date**

Kokomo, Indiana

AUTHORIZATION TO RELEASE HEALTH INFORMATION

DP 60159
Revised: 7/1/2008

 Original - Chart