AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please select a location

_____ Hammond- 5454 Hohman Avenue, Hammond, IN 46320
_____ Dyer- 24 E Joliet Street, Dyer, IN 46311
_____ Munster- 701 Superior Avenue, Munster, IN 46321
_____ Michigan City– 3500 Franciscan Way, Michigan City, IN 46360
_____ Crown Point – 1201 S. Main St., Crown Point, IN 46307
_____ Lafayette Central – 1501 Hartford Street, Lafayette, IN 47904
_____ Lafayette East – 1701 S. Creasy Lane, Lafayette, IN 47905
_____ Crawfordsville - 1710 Lafayette Rd., Crawfordsville, IN 47933
_____ Rensselaer- 1104 East Grace Street, Rensselaer, IN 47978
_____ Indianapolis- 8111 S. Emerson Avenue, Indianapolis, IN 46237
_____ Mooresville -1201 Hadley Road, Mooresville, IN 46158
_____ Carmel- 12188 B North Meridian Street, Carmel, IN 46032
_____ Chicago Heights- 1423 Chicago Road, Chicago Heights, IL 60411
_____ Olympia Fields- 20201 South Crawford Avenue, Olympia Fields, IL 60461
_____ Franciscan Lakeshore ASC, LLC-12800 Mississippi Parkway, Pavilion C, Crown Point IN, 46307

I AUTHORIZE FRANCISCAN HEALTH TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S).

Patient Name (*Please Print):*_____

Patient Address: _____

Date of Birth:_____ Last 4 Digits of Social Security #_____ Patient Telephone #: _____

Covering the period(s) of treatment: _____

INFORMATION TO BE RELEASED:

_____Discharge Summary	_____Radiology (X-ray, CT Scan, MRI)	_____ER record
_____History & Physical	_____EKG	_____Lab Results
_____Operative Report	_____Consultations	_____Patient Bill (UB04/1500)

_____Complete Health Record (this is the legal medical record as defined by the hospital)
_____Other (specify):_____

INFORMATION TO BE RELEASED TO:

Name:_____

Address/City/State/Zip:_____

Telephone #:_____

PURPOSE OF DISCLOSURE: ❑Continuation of Care ❑Insurance ❑Attorney ❑Personal Use ❑Other

I understand this authorization can be revoked by me at any time in writing to Franciscan Health except that disclosure made in good faith has already occurred in reliance on this authorization. Franciscan Health will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations.

I understand that a fee may be charged for preparing a copy of the requested records. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. 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 in 60 days. Your protected health information will be provided to you in paper format. If you wish for your protected health information to be provided to you in a secure electronic form, you must initial here:_____. Documents will be provided in a .pdf file format. Select the electronic format:

❑MyChart (patient only) ❑CD/DVD ❑USB ❑Email

Franciscan HEALTH

Patient Name:_____

Account #:_____

Medical Record #:_____

Release of Information

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Email address required for records to be released in electronic format_____

The password for accessing your electronic media is:_____

_____ By initialing here, I understand that unencrypted e-mail or media (e.g., CD, DVD, USB Flash Drive, etc.) is not considered a confidential means of communication. I have been offered a secure method to receive my records and I have chosen to receive without the protection of encryption. I agree to waive any rights that I may have against Franciscan Health, any affiliated organization, or physician, or the suppliers, for any compromised information due to the technical failures and/or unintended breach of confidentiality.

I understand that this release also pertains to records regarding the testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or for psychiatric treatment or counseling or communicable disease, or genetic testing unless I have initialed here:**_____.

SIGNATURE:_____ DATE:_____

RELATIONSHIP TO PATIENT, if other than patient:_____

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable):_____

WITNESS SIGNATURE:_____ DATE:_____

Franciscan HEALTH

Patient Name:_____

Account #:_____

Medical Record #:_____

Release of Information