All areas highlighted must be filled out completely and legibly!

AUTHORIZATION TO RELEASE HEALTH INFORMATION

FAX: (317) 329-2531
Mail: HIM Dept, 4141 Shore Drive, Indianapolis, IN 46254

PATIENT INFORMATION

Name: John L. Doe **Date of Birth:** 12/5/1999

Address: 5555 Rehab Way

City: Indianapolis **State:** IN **Zip:** 55555 **Phone:** 317-555-1212

RECEIVING PARTY:

☐ Patient **X** Other

Name: XYZ Disability Associates

Address: 5555 Disability Way

City: Indianapolis **State:** IN **Zip:** 55555

Phone: 317-123-4567 **Fax:** 317-987-6543

INFORMATION TO BE RELEASED:

(What do you want sent or released? Check the box.)

Date(s) of Service: From: 01 / 01 / 2020 To: 12 / 31 / 2020

X Hospital Medical Records ☐ Outpatient/Clinic Medical Records ☐ Billing Records

Check the boxes below if you ONLY want these records to be released:

☐ Discharge Summary	☐ Medication Records	☐ Lab Reports
☐ History and Physical Exam	☐ Therapy Notes/Evaluation	☐ Outpatient Notes
☐ Plan of Care	☐ Consultations	☐ Radiology Records
☐ Progress Notes	☐ Other _____	

SPECIAL AUTHORIZATION REQUIRED:

(Per IC-16-39-2, this special authorization is valid for 180 days)

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	**X** YES	☐ No	Dates: 1/1/2020 – 2/28/2020
HIV Testing and Results	☐ YES	☐ No	Dates: _____
Mental Health Records	☐ YES	☐ No	Dates: _____
Psychotherapy Records	☐ YES	☐ No	Dates: _____
Genetic Records	☐ YES	☐ No	Dates: _____

RELEASE INSTRUCTIONS

☐ Paper **X** Fax: 317-987-6543

Date information is needed: 6/5/2021

NOTE: RHI does not email medical record information. Please allow 30 days for processing.

PURPOSE OF RELEASE:

☐ Personal Use*	☐ Insurance Application*	☐ Social Security *
☐ Medical Care	☐ Litigation/Legal*	☐ Workman's Compensation*
☐ Resource Facilitation	**X** Disability Application*	Other*: _____

***Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 CFR §164.524**

This authorization will expire **one (1) year** from the date signed unless otherwise specified: N/A. I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization. I understand that I am not required to sign this Authorization in order to receive health care treatment. RHI's records may include records that it receives from other organizations. If these records have been used by RHI and filed in the record RHI maintains about you, these records may be released with your RHI records. RHI cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release RHI from any and all liability resulting from a redisclosure by the recipient.

PLEASE FILL OUT FORM COMPLETELY. SUBMITTING AN INCOMPLETE FORM WILL RESULT IN PROCESSING DELAYS.

Your signature indicates that you have read and understand this form, and you authorize release of your information as described above.

John L. Doe 5/31/2021

Patient/Legal Guardian Signature **Date**

HIM Received: _____

Staff Initials: _____

1018

_____

Authority to act on behalf of patient (Attach documentation)

*Revised 4/2019