

# Authorization to Disclose Health Information

Patient Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

I authorize the following individual or office to make the Disclosure:

\_\_\_\_\_

Address \_\_\_\_\_

I authorize the use or disclosure of the above named individual's health information as described below

### INFORMATION TO BE RELEASED: (Specify Dates)

This type and amount of information to be used or disclosed is as follows: (include dates, if appropriate. Be specific, for example state "Lab results from July 1998")

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Office/ Progress Note | <input type="checkbox"/> Consultation       | <input type="checkbox"/> Prescriptions   |
| <input type="checkbox"/> Test / Procedure      | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Allergy Records |
| <input type="checkbox"/> History & Physical    | <input type="checkbox"/> X-Ray Reports      | <input type="checkbox"/> Entire Record   |
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Other _____        | <input type="checkbox"/> Other _____     |

I authorize the release of information protected by Federal and State Regulations including alcohol/substance abuse, mental health documentation, and HIV results.

For the Following Dates \_\_\_\_\_

This information may be disclosed to and used by the following individual or organization:

Heart Partners of Indiana, LLC  
8075 N. Shadeland Ave., Suite 350  
Indianapolis, Indiana 46250  
Phone: 317.621.9700 Fax: 317.621.9733  
Medical Care

Heart Partners of Indiana, LLC  
1210 B Medical Arts Blvd., Suite 114,  
Anderson, Indiana 46011  
Phone: 765.298.4425 Fax: 765.298.4925  
Medical Care

### YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I **have the right to inspect or copy the health information** I have authorized to be used or disclosed by this authorization form, as provided in CFR 164.524. I understand that if I agree to sign this authorization, which I am not required to do, **I will be provided with a signed copy of the form upon request.** I understand that I **have a right to withdraw this authorization at any time.** I understand that if I withdraw this authorization I must do so in writing and present my written withdrawal to the Health Information Services Department of the entity listed above. I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that the withdrawal 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 withdrawn, this authorization will expire on the following date/event, or condition specified below.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Heart Partners of Indiana and its Entities Privacy Official at 1.866.976.9700.

If I fail to specify an expiration date, event or condition, this authorization will expire in sixty (60) days.

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

(If signed by Legal representative, state relationship and authority to do so) \_\_\_\_\_ Signature of Witness \_\_\_\_\_

**Patient Is:**  Minor  Incompetent  Disabled  Deceased

**Legal Authority:**  Custodial Parent  Legal Guardian  Executor of Estate of Deceased  Power of Attorney for Healthcare  
 Authorized Legal Representative of Healthcare

Received by: \_\_\_\_\_ Date: \_\_\_\_\_