AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____
Patient's Name

_____
Patient's Address

_____
City, State, Zip Code

_____ _____ _____
Telephone Number **Date of Birth Social** **Security Number**

The undersigned hereby authorizes MARION GENERAL HOSPITAL, 441 NORTH WABASH AVENUE, MARION, IN 46952, to release the following portions of the medical record(s) of the above named patient during the time period of: _____ (approximate dates)

___Discharge Summary **___Laboratory Report(s)** **___Emergency Treatment**
___History & Physical Report **___X-Ray Report (s)** **___Other (specify) _____**
___Operative Report **___Pathology Report _____**

<u>RELEASE THIS INFORMATION TO</u>:

_____
Name of person, physician, attorney, hospital, clinic or institution

_____ _____ _____
Address of above **City State** **Zip Code**

<u>THE MEDICAL RECORD IS REQUESTED FOR THE FOLLOWING PURPOSE</u>:

_____Attorney **___Insurance**
_____Continued Medical Treatment/Follow-up **___At the request of the individual**
_____Workmen's Compensation Claim **___Disability**
_____Employer **___Other: _____**

I understand that I may REVOKE this release at any time, by writing to Marion General Hospital's Privacy Officer, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I also understand that this release may include medical records of treatment for *<u>physical and/or emotional illness, including treatment of alcohol or drug abuse</u>*. I also understand that *<u>HIV, AIDS or AID-related and/or communicable disease</u>* information may also be released. I also understand the released information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy law.

_____ _____
Signature (Designated by Law) **Date of Signature**

_____ _____
Relationship (If other than patient) **Witness**

Call Taken By: _____ Date Copies Ready:_____ Copies Made By:_____
Contacted By: _____ Date Contacted: _____ Amount Charged: _____
Released By: _____ Date Released: _____

Health Information Management
Address: 500 N. Wabash Ave., Suite 112
Marion, IN 46952-2690
Telephone: (765) 660-6060
Fax: (765) 662-4193
Hours: Monday through Friday, 8 a.m. – 4 p.m.