Vermillion-Parke Community Health Center

777 S. Main Street, Suite 100, Clinton, IN 47842
Phone: 765-828-1003; Fax: 765-828-1030

114 N. Division Street, Cayuga, IN 47928
Phone: 765-492-9042; Fax: 765-492-9048

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Date of Request: _____ **Purpose of Disclosure:**

_____ Patient Name _____ Street Address _____ City/State/Zip _____ Phone Date of Birth	_____ Referring Physician to Physician _____Continuing Care/Second Opinion _____Personal _____Attorney _____ Employer _____Disability _____Insurance _____Other

Physician where medical records will be obtained: **Information Requested:**

_____ Name _____ Street Address _____ City/State/Zip	_____Recent/Pertinent Laboratory Results _____Radiology Reports _____EKG report/tracing _____Consultant Letters _____Any Pertinent Medical History (abnormal results, etc.) _____All the above

This authorization shall be in force and effect for 60 days at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to the Vermillion-Parke Community Health Center. I understand that a revocation is not effective to the extent that the Vermillion-Parke Community Health Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this information may be subject to re-disclosure by the recipient and may be no longer protected by federal or state law.

Vermillion-Parke Community Health Center will not condition my treatment, payment, enrollment in a health plan or eligibility benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

I do not want the following information released/obtained:

_____ Alcohol
_____ Depression
_____ Hepatitis
_____ Drugs
_____ Sexually transmitted diseases
_____ HIV/AIDS

_____ _____
Signature of Patient or Personal Representative Date