Hendricks Regional Health

Authorization for the Use or Disclosure of Health Information
Other Facility

I authorize _____ and/or any of its affiliates to release my health information, as outlined, to be used or disclosed to the following **person or facility**:

Hendricks Regional Health DBA Brownsburg North Family Medicine
5492 N Ronald Reagan PKWY suite 250
Brownsburg, IN 46112
Phone 317-852-3851 Fax 317-852-1246

For the purpose of: _____

Patient Information:

Patient Name: _____ DOB _____

Address _____ SSN _____

City/State/Zip _____ Phone _____

Description of Protected Health Information to be Disclosed:
(Please check records to be disclosed pursuant to this authorization)

How information is to be disclosed: ☐ Copy & release information ☐ View information

Dates of Treatment : _____

Medical Record: ☐ Visit notes ☐ Lab/x-ray reports ☐ Immunization records ☐ Other _____

I understand that visit notes may include use of tobacco and alcohol, depression, ADD/ADHD etc.

- This authorization is only valid for 60 days.
- I have the right to revoke this authorization in writing, except if the releasing facility listed above has taken action in reliance upon this authorization. Or, if this authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.
- My Protected Health Information that is used or disclosed under the authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by law. Hendricks Regional Health cannot be held liable for such re-disclosures.
- Treatment cannot be conditioned upon obtaining this authorization.
- **You may be charged by the releasing facility listed above or their designated copy service, the maximum allowable by law for medical record copies.**
- Reasonable notice is required regarding notification and disclosure of Protected Health Information (PHI).

By signing below, I am authorizing the release of the Protected Health Information outlined above and acknowledge I have **read, understand and received a copy of this authorization**.

_____ _____
Signature of Patient Date

_____ _____
Signature (Authorize Representative) Date

_____
Printed Name

_____
Description of Authorized Representatives relationship/ authority to sign for patient (i.e. Power of Attorney)

_____
Signature of Witness

_____
Date