Memorial
EPWORTH CENTER℠

BEACON HEALTH SYSTEM℠ Care Partner

Place Label Here

420 North Niles Avenue South Bend, IN, 46617
Medical Records: 574-647-8216 Medical Records FAX: 574-647-8220

Patient Name (Last, Middle, First): _____

Date of Birth:_____/_____/_____

Address:_____ **Telephone Number:** (_____)_____

City, State, Zip:_____ _____ **Previous Last Name:** _____

CHOOSE THE BOX THAT APPLIES: ☐ **Release my Memorial Epworth Center's records to**: ☐ **Obtain my records from**:

Individual / Agency Name: _____

Address: _____

City, State, Zip:_____ Fax Number if urgent: _____

DESCRIPTION OF INFORMATION THAT MAY BE USED AND DISCLOSED:

Dates of Treatment: _____to _____

☐ Entire chart ☐ History & Physical ☐ Psych Evaluation ☐ Treatment Plans ☐Laboratory / Drug Screen Reports

☐ Physician Progress Notes ☐ Discharge Summary / Discharge Instructions ☐ Dates of Admission and Discharge ☐ Social Services Notes

Other specific information: _____

INITIAL HERE: _____ **I hereby understand that my records may contain information regarding the diagnosis or treatment of mental illness or psychiatric treatment, a communicable disease, HIV, AIDS or AIDS related illness, and/or Drug and Alcohol abuse. By initialing above, I give my permission for these records to be released.**

CHOOSE ONE DELIVERY METHOD: ☐ Mail ☐ CD/Electronic Format ☐ Patient will pick up when ready ☐ **Review chart in person

CHOOSE PURPOSE FOR DISCLOSURE: ☐ Continuity of Care ☐ Attorney/Legal ☐ Disability/Insurance ☐ *Personal Use ☐_____

Personal Use*: *I understand that under certain circumstances, Memorial Epworth Center may deny access to some or all of the information requested for personal use. In this event, Memorial Epworth Center will provide a written explanation to me. I understand that Memorial Epworth Center will either act on my request to provide access or issue a written denial within 30 days. Memorial Epworth Center may take one extension of up to 30 days. If this is necessary, Memorial Epworth Center will provide written notice of this extension. (IC 16-39-2-4) ** Reviewing chart in person will be with Medical Record Staff in electronic format.

This authorization is completely voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient. I understand that there may be a charge/fee for copies of medical records. I understand that Memorial may receive compensation for the use and disclosure of the information. **Revocation:** I understand that I may revoke this authorization at any time by writing to Medical Record Department Memorial Epworth Center unless action has already been taken in reliance upon this authorization. **Expiration:** Authorization will expire 60 days from the date it is signed.

_____ **Date Signed:**_____/_____/_____

SIGNATURE OF PATIENT (minor child if required) GUARDIAN OR LEGAL REPRESENTATIVE

Name of Legal Representative:_____ **Relationship to Patient:** _____

☐ Patient was given a copy of this Authorization

576530

AUTHORIZATION FOR RELEASE OF INFORMATION