



### AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Check 1 site per form. Complete entire form and sign/date.

- Beacon Medical Group\*/Beacon Health, LLC/Med Point Bremen Elkhart General Hospital Memorial Hospital/Epworth

\*Beacon Medical Group site-name/address/Doctor's Name:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Patient Information section with fields for Name of Patient, Address, City, State, ZIP, Ph#, and Previous Name(s).

- Release and disclose my Protected Health Information to: Receive my Protected Health Information from:

Fields for Name, Ph#, Fx#, Address, City, State, and ZIP for the recipient.

Dates to be released: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

- Clinic Records Hospital Summary Medication Lists Billing Records Face Sheet Labs Radiology Discharge Summary ER - Emergency Room Records Operative/Procedure Reports Immunization Records Consult Copies of Films/Images Other

\*\* By selecting one or more of the \*\* boxes below, I specifically authorize these records to be released or shared:

- Behavioral health/Mental illness records Treatment of Communicable Disease, including HIV/AIDS, hepatitis and venereal diseases, etc. Substance abuse treatment (i.e., alcohol and/or drug) Genetic Testing/Screening

#### Delivery Method

- Mail CD/DVD (not available w/all records) Electronic Delivery List valid email address for Electronic Delivery (please print)

#### Purpose of Release

- Attorney/Legal Insurance Other:

There may be charges associated with processing a request and producing requested records. These charges do not apply for copies requested for continuing medical care. This authorization will expire 60 days from the date it is signed by me. I understand that the health information described above may be disclosed by the recipient and the information may no longer be protected by federal privacy regulations. I understand that Beacon Health System may receive compensation for the use and disclosure of the information. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this Authorization at any time by submitting my request in writing to the Privacy Officer at 615 North Michigan Street, South Bend, IN. 46601. By signing this Authorization, I acknowledge that I have read this Authorization. Further, I authorize the use and disclosure of my Protected Health Information in accordance with the terms of this Authorization.

Signature of Patient or Personal Representative: Date/Time: Printed name of Patient or Personal Representative: Relationship to Patient (Personal Representative - provide documentation )