

Place Label Here

**AUTHORIZATION FOR THE USE OR DISCLOSURE
OF PROTECTED MEDICAL INFORMATION**

PATIENT IDENTIFICATION

PATIENT INFORMATION																		
NAME		TELEPHONE ()	PREVIOUS ADMISSION NAME, IF DIFFERENT															
ADDRESS		BIRTH DATE	MR #															
CITY/STATE/ZIP		DATES OF SERVICE FROM _____ TO _____																
Person(s) or class of persons authorized to receive the information: Name: _____ Address: _____ City/State/Zip: _____																		
Description of information that may be used and disclosed: <table border="0"><tr><td><input type="checkbox"/> Entire Chart</td><td><input type="checkbox"/> Laboratory Report(s)</td><td><input type="checkbox"/> Abstract only: Discharge Summary,</td></tr><tr><td><input type="checkbox"/> Face Sheet</td><td><input type="checkbox"/> Radiology Report(s)</td><td>History & Physical, Operative Report,</td></tr><tr><td><input type="checkbox"/> Discharge Summary</td><td><input type="checkbox"/> Operative Report(s)</td><td>Laboratory, Radiology, Consults, EKGs</td></tr><tr><td><input type="checkbox"/> History & Physical</td><td><input type="checkbox"/> Other: _____</td><td></td></tr><tr><td><input type="checkbox"/> Consult Report(s)</td><td></td><td></td></tr></table>				<input type="checkbox"/> Entire Chart	<input type="checkbox"/> Laboratory Report(s)	<input type="checkbox"/> Abstract only: Discharge Summary,	<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Radiology Report(s)	History & Physical, Operative Report,	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Report(s)	Laboratory, Radiology, Consults, EKGs	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Other: _____		<input type="checkbox"/> Consult Report(s)		
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<input type="checkbox"/> History & Physical	<input type="checkbox"/> Other: _____																	
<input type="checkbox"/> Consult Report(s)																		
The information will be used and disclosed for the following purposes: <input type="checkbox"/> Personal Use <input type="checkbox"/> Attorney/Legal <input type="checkbox"/> Continuing Patient Care <input type="checkbox"/> Insurance <input type="checkbox"/> Other: _____																		
DELIVERY METHOD: <input type="checkbox"/> Mail <input type="checkbox"/> Patient will pick up when ready <input type="checkbox"/> Review chart in person <input type="checkbox"/> CD																		
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 Memorial Hospital of South Bend may receive compensation for the use and disclosure of the information.																		
I understand that Memorial Hospital of South Bend will not condition my ability to obtain treatment on the provision of this Authorization.																		
This Authorization request does not apply to any dates of service beyond date of signature.																		
I understand that I may revoke this Authorization in writing at any time by writing to Medical Records Department – Memorial Hospital of South Bend unless action has been taken in reliance upon this Authorization. This Authorization expires 60 days from the date it is signed by me. I understand that the medical information released may contain information concerning treatment of physical and/or emotional illness, drug and/or alcohol abuse, mental health, communicable disease, HIV, AIDS or AIDS-related illness. I understand there is a charge for copying medical records at a fee of \$20.00 up to ten (10) pages and \$.50 for each additional page, plus postage. These charges do not apply for copies requested for continuing medical care. By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my health information in accordance with the terms of this Authorization.																		
SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE		DATE SIGNED	TIME															
NAME OF GUARDIAN OR LEGAL REPRESENTATIVE		RELATIONSHIP TO PATIENT																

☐ Check here if you are a Memorial Hospital/Beacon Health System employee.

☐ Patient was given a copy of this Authorization.

Original - Medical Records Copy - Patient

