

**AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION**

\_\_\_\_\_ Franciscan Health Lafayette Central – 1501 Hartford Street, Lafayette, IN 47904

\_\_\_\_\_ Franciscan Health Lafayette East – 1701 S. Creasy Lane, Lafayette, IN 47905

**I AUTHORIZE FRANCISCAN HEALTH TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S).**

Patient Name (Please Print): \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_ Patient Telephone #: \_\_\_\_\_

Covering the period(s) of treatment: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

_____ Discharge Summary	_____ Radiology (X-ray, CT Scan, MRI)	_____ ER record
_____ History & Physical	_____ EKG	_____ Lab Results
_____ Operative Report	_____ Consultations	_____ Patient Bill (UB04/1500)
_____ Complete Health Record (this is the legal medical record as defined by the hospital)		
_____ Other (specify): _____		

**INFORMATION TO BE RELEASED TO:**

Name: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

**PURPOSE OF DISCLOSURE:**  Continuation of Care  Insurance  Attorney  Personal Use  Other

I understand this authorization can be revoked by me at any time in writing to Franciscan Health except that disclosure made in good faith has already occurred in reliance on this authorization. Franciscan Health will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations.

**I understand that a fee may be charged for preparing a copy of the requested records.** I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_  
\_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days.

Your protected health information will be provided to you in paper format. If you wish for your protected health information to be provided to you in a secure electronic format, you must initial here: \_\_\_\_\_. Documents will be provided in a .pdf file format. Select the electronic format:  CD/DVD  USB  Email

Email address records should be sent to: \_\_\_\_\_

The password for accessing your electronic media is: \_\_\_\_\_

\_\_\_\_\_ By initialing here, I understand that unencrypted e-mail or media (e.g., CD, DVD, USB Flash Drive, etc.) is not considered a confidential means of communication. I have been offered a secure method to receive my records and I have chosen to receive without the protection of encryption. I agree to waive any rights that I may have against Franciscan Health, any affiliated organization, or physician, or the suppliers, for any compromised information due to the technical failures and/or unintended breach of confidentiality.



Patient Name: \_\_\_\_\_

Account #: \_\_\_\_\_

Medical Record #: \_\_\_\_\_



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I understand that this release also pertains to records regarding the testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or for psychiatric treatment or counseling or communicable disease, or genetic testing unless I have initialed here:**\_\_\_\_\_.

SIGNATURE:\_\_\_\_\_ DATE:\_\_\_\_\_

RELATIONSHIP TO PATIENT, if other than patient:\_\_\_\_\_

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable):\_\_\_\_\_

WITNESS SIGNATURE:\_\_\_\_\_ DATE:\_\_\_\_\_



Patient Name:\_\_\_\_\_

Account #:\_\_\_\_\_

Medical Record #:\_\_\_\_\_