JOHNSON MEMORIAL HEALTH

1125 West Jefferson St. | Franklin, Indiana | 46131

(To Be Completed by JMH Staff)
MRN#: _____
FIN#: _____

REQUEST AND AUTHORIZATION TO OBTAIN AND/OR RELEASE MEDICAL INFORMATION

I, the undersigned, hereby request and authorize disclosure of the indicated Medical Records from the following facility. (Please check box)

Johnson Memorial Health (hospital and/or hospital outpatient clinics):

□ Hospital □ Breast Center □ Immediate Care □ Pain Relief Specialists □ Occupational Health □ Oncology □ Wound Healing

Johnson Memorial Health Physician Network (JMH physician offices):

□ Family Practice □ Internal Medicine □ Orthopedic Surgery & Sports Medicine □ Pediatrics □ Surgical Specialists □ Women's Care Group OB/GYN

□ **Obtain / Release Medical Records From - Facility Name:** _____ City/State: _____

SECTION 1 - PATIENT INFORMATION (Please Print)

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Telephone Number: _____ Alternate Telephone Number: _____

SECTION 2 – INFORMATION TO BE RELEASED

Date(s) of service to be released from: _____/_____/_____ through _____/_____/_____

□ Pertinent Medical Records (dictations, labs, x-rays)
□ Physician Office Notes (Dr. _____)
□ Rehabilitation / Therapy Records (PT, OT, Speech)
□ Pathology
□ Consultation
□ Facesheet
□ Emergency (ER) Report
□ Discharge Summary / Instructions
□ Operative (Surgery) Report
□ Radiology Report
□ Radiology Images/Films (on a CD)
□ Other: _____
□ Itemized Bill
□ Immunization Record
□ Paternity Affidavit
□ Lab Results
□ Cardiology

****Special Authorization*** State & Federal Laws protect the following health information.*
If your medical record may contain any of the protected health information below, please indicate if you would like to have this data released.

Alcohol, Drug or Substance Abuse Records	□ *Yes*	□ *No*
HIV Test and Results	□ *Yes*	□ *No*
Mental Health Records	□ *Yes*	□ *No*
Psychotherapy Records	□ *Yes*	□ *No*

SECTION 3 – RELEASE INFORMATION TO THE FOLLOWING FACILITY/PERSON

□ Me/Patient □ Other (see below)

Company / Name: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Ext: _____ Fax Number: _____

SECTION 4 – PURPOSE OF RELEASE

□ Personal / Patient Use* □ Attorney / Legal Request* □ Insurance* □ Social Security / Disability*
□ Continuing Care / Physician □ Workman's Comp □ School / Daycare □ Other: _____

*Fees may be applied in accordance with Indiana Statute 760IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

SECTION 5 – ACKNOWLEDGEMENT AND CONSENT TO RELEASE HEALTH INFORMATION

- This authorization will expire in 60 days from the date signed unless otherwise specified here:_____
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization. Also, if applicable, I understand that JMH may charge for medical record copies.
- I understand that JMH cannot prevent re-disclosure of my information by the person/company who receives my data as directed by this authorization. By signing this authorization, I release JMH from any and all liability resulting from a re-disclosure by the recipient.
- I understand that my JMH record may contain data that was received from another facility & it may be released as part of this request.

Your signature indicates that you have read and understand this form and you authorize release of your JMH medical record as described above.

_____ _____ _____AM/PM

Patient Signature (or Legal Representative**) Date Time

**If applicable, attach documentation of authority to act on behalf of patient.

To Be Completed By JMH Release of Information Staff:
Signature Verified Via: Photo ID ____ Signature on File ____
Initials of Staff Releasing Records: _____ Date: _____