Community Health Network

PATIENT IDENTIFICATION

AUTHORIZATION TO RELEASE PATIENT MEDICAL RECORDS

Not to be used VERBAL communication

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ Last 4 digits of SS#: _____

Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____

Clinic/Hospital/ Healthcare Provider-

(**Who** has the information you want released? Please list the specific Hospital and/or clinic)

LOCATION of service provided. Please check all that apply,

COMMUNITY HOSPITAL:
- ☐ Anderson
- ☐ East
- ☐ Heart & Vascular (a facility under CHE)
- ☐ North
- ☐ South
- ☐ Westview (a facility under CHE)
- ☐ Howard Regional Health
- ☐ Howard Specialty Hospital

COMMUNITY SURGERY CENTER:
- ☐ East
- ☐ Hamilton
- ☐ Howard
- ☐ North
- ☐ Northwest
- ☐ Plus
- ☐ South
- ☐ Digestive Centers Anderson
- ☐ Endoscopy Center Indianapolis

OTHER:
- ☐ Cancer Centers
- ☐ Community Fairbanks Behavioral Health
  - ☐ Inpatient ☐ Outpatient
- ☐ Community Fairbanks Behavioral Health Howard
- ☐ Home Health
- ☐ Imaging Centers
- ☐ Medchecks
- ☐ Physical Therapy Offices
- ☐ Physician Network

Physician _____ Practice Name _____

Receiving Party

(**Where** do you want the information sent or released? Who may have the information?)

NAME: _____

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

Day Phone: _____ Fax Number _____

Information to be Released

(**What** do you want sent or released? Check the appropriate box(es).)

Disclosure will include (check all that apply):

☐ Consultation Report	☐ Discharge Summary/Notes	☐ Emergency Record(s)	☐ History and Physical Report	☐ Forensic Photos	☐ Entire Record
☐ Immunization/Allergy Records	☐ Laboratory/Pathology Report	☐ Medication Report	☐ Office Visits	☐ Operative Report	☐ Communicable Diseases
☐ Progress Notes/Clinic Notes	☐ Films/Images	☐ Therapy Records	☐ X-ray/Radiology Report	☐ Forensic Consult	☐ Billing Records
☐ Substance Abuse Records	☐ Mental Health Records	☐ BH Treatment Plan	☐ BH Diagnosis	☐ BH Evaluation/Assessment	

☐ Other records specify record type(s) _____

Date(s) of Service _____ Illness or injury _____

Release Instructions

(**How** and **When** do you want the information?)

Date information is needed: _____ (NOTE: PLEASE ALLOW 30 DAYS FOR PROCESSING)

Release Method/Format requested: (check one)

☐ MyChart ☐ Paper ☐ CD/DVD ☐ Fax ☐ Secure Email ☐ Electronic Format _____

Purpose of Release

(**Why** is it needed?)

☐ Continuing care	☐ Transfer of care	☐ Social security appeal	☐ Insurance application*
☐ At the patient's request*	☐ Social security disability	☐ Insurance payment/claim	☐ Litigation/legal determination*

☐ Other* _____

*Fees may be charged in accordance with IN Statutes and Federal Rule 45 C.F.R. 164.524

- This authorization lasts for 60 days after the date I sign it unless I enter a different date or expiration here: _____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happened before the cancellation. The Community Health Network Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- **Unless I have limited above,** I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.
- Community cannot prevent re-disclosure of my information by the person or organization who receives my records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, I release Community from any and all liability resulting from a re-disclosure by the recipient.
- I understand that I may refuse to sign this authorization, and my refusal will not affect my ability to obtain services, treatment or payment for services; **unless services provided are solely to create health records for a third party, such as physical and drug testing for an employer or insurance company; or if treatment provided is research related and authorization is required for the use of health information for research purposes.**
- My signature indicates that I read and understand this form, and authorize release of my information as described above.

_____ Patient/Legal Guardian Signature

_____ Date/Time

_____ Authority to act on behalf of patient (attach document)

PLEASE PROVIDE A COPY OF THIS FORM TO THE PATIENT.

RELEASE OF INFORMATION

Community Health Network

DIRECTIONS FOR COMPLETION OF THIS FORM

Patient Name: _____ Date of Birth: _____

Directions for Completion of this Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for).

Clinic/Healthcare Provider: Identify which Community Health Network facility you are seeking information from (or to be sent to). **Please be specific** in your request. For example, when choosing Community Physician Network please add either the name of the provider or the practice name you are requesting. If you do not identify a specific facility records may be provided to **ALL** Community Health Network facilities where you have received care. Please see www.eCommunity.com for a listing of Community Health Network locations and names.

Receiving Party: Identify the full name/business, address, phone and contact information with the name of the individual who is to receive the information. *Please allow 30 days for all requests to be processed and sent to the recipient.*

Information to Be Released: This section gives us the instructions for what information you want released.

Release Instructions: This tells us how you would like your information delivered. We can print the documents, mail, secure email, or create a CD. If we are unable to provide in the format desired we will contact you to make other arrangements.

Purpose of Request: You are not required to provide a reason for your request however, this helps us to track and assign priority to your request. It also informs us who may be responsible for the cost of records (where appropriate).

FEES: State and Federal laws permit fees to be charged for medical records. We do not charge patients for copies of their records

Contact Information

Community Health Network
Health Information Management-ROI
1500 North Ritter Avenue
Indianapolis, IN 46219

Phone: 317.355.5802
Fax: 317.351.7728

For any questions/follow-up regarding your request please e-mail **releaseofinformation@eCommunity.com**

To submit a request for records please e-mail to **ROIRequests@eCommunity.com**