2605 N. Lebanon Street
Lebanon, IN 46052
765-485-8000

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Witham Health Services to use or disclose my Protected Health Information to:

Name: ______________________ Address: ______________________

City/State/Zip: ____

FROM THE MEDICAL RECORDS OF:

Name: ______________________ Date of Birth: ____________ S.S.# ____________

Address: ______________________ City: ____________ State: _____ Zip: _______

USE / DISCLOSE THE FOLLOWING INFORMATION

____ Discharge Summary ____ Radiology (X-Ray, CT scan, MRI) ____ Emergency Room Record
____ History & Physical ____ EKG ____ Lab/Pathology Reports
____ Operative/Procedure Report ____ Consultations ____ Complete Health Record
____ Other (Specify): ____

Release Method/format request: (check one)
____ Paper ____ CD/Electronic format

FOR THE FOLLOWING DATE OF TREATMENT: (Including information about treatment for psychiatric illness, drug/alcohol abuse, HIV/AIDS)
All Medical Records? _____YES _____No Specific Date(s) of Treatment? ______________________

For the purpose of: ___Continuity of Care ____ Insurance ____ Attorney ____Personal Use ____ other

I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if:

- Witham Health Services has taken action in reliance upon this Authorization;
- Or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law. I understand that PHI may include information related to sexually transmitted disease, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization. **Authorization Expires: Six months from date of signature unless otherwise specified.**

*This authorization must be signed by the PATIENT. In the case of an un-emancipated minor (under age 18) patient, this authorization must be signed by a parent or guardian. In the case of a patient who has been declared mentally incompetent, this authorization may only be signed by a legally appointed guardian. In the case of a deceased patient, this authorization must be signed by the executor/administrator to the estate. If the deceased patient has no personal representative, then this authorization must be signed by the spouse; if there is no spouse, this authorization must be signed by parent, an adult sibling, or an adult child of the deceased patient.

DATE/TIME: ____________________ Signature of patient ______________________

______________________ ______________________
Signature of Authorized Representative Name (please print)

______________________ ______________________
Relationship of Authorized Representative Signature (Witness) Date/Time

Return this form to:
WithamHealthRecords@witham.org or
2605 N. Lebanon St, Lebanon, IN 46052

For Internal Use Only

Medical Record Number: ______________________

Use / Disclosure Completed By: ______________________
Signature / Date/Time

 # Pages: _______ ▢ **in person** ▢ **Mailed** ▢ **Faxed**

Patient Received CD/Electronic format ▢ **Date of receipt/mailed:** __________