Evansville Multi-Specialty Clinic, PC

812-475-1948 • Toll Free: 1-888-401-4DOC • Fax: 812-401-1267 • www.evvclinic.com
6140 E. Columbia Street, Evansville IN 47715

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

Patient Name: ____ **Date**: _________________

Social Security Number: ____________________________ **DOB**: _______________

Entity Requested to Release Information: (who you want to release records)

Practice/Provider Name: ____

Phone: ______________________________ Fax:_________________________________

Practice/Provider Name: ____

Phone: ______________________________ Fax:_________________________________

Practice/Provider Name: ____

Phone: ______________________________ Fax:_________________________________

Entity Authorized to Receive Information: (who you want to get your records)

Practice/Provider Name Evansville Multi-Specialty Clinic

Phone: 812-475-1948 Fax: 812-401-1267

Description of information to be disclosed- I authorize the practice to disclose the following protected health information about me to the entity or person identified above:

O Entire patient record (this does include HIV/STD records); **OR**, check only those items of the record to be disclosed.
O Office Notes O Labs O X-rays
O Hospital, nursing home, home health, hospice
O Record of HIV and communicable disease testing
O Record of mental health or substance abuse treatment
O Only send the following: ____
____

Dates of information to be released:
O All
O From ___________ To ___________

Purpose of disclosure: (please describe the purpose of request)
O Continuity of Care
O Legal
O Other: _________________________

I am aware that such record may contain information related to mental health, substance abuse (alcohol/drug) and sexually transmittable diseases including HIV/AIDS as long as I specifically authorized the release of such information pursuant to this authorization. I understand this authorization will remain in effect for 1 year, but may be revoked at any time in writing. I further understand that any such revocation will not apply to any information already released under this authorization. I understand that I am under no obligation to sign this authorization and that my ability to obtain treatment will not depend on such authorization. I understand that I have a right to receive a copy of this authorization. I understand that State and Federal law may prohibit the recipient from re-disclosing information pursuant to this authorization. I hereby release Evansville Multi-Specialty clinic, PC from any and all liability related to reliance upon this authorization or the release of information pursuant to this authorization.
FEE FOR COPIES: Federal and state law permit a fee to be charged for copying of patient records. Please see additional fee sheet for charges that apply. All fees must be collected prior to releasing your information.
Re-disclosure: We have no control over the entities or person(s) you have listed to receive your protected health information (PHI). Therefore, your PHI disclosed under this authorization will no longer be the responsibility of the practice releasing the PHI and, depending upon the entity receiving it, may no longer be protected by the requirements of the Privacy Rule.

____ ________________
Patient Signature Date

____ _________________________
Personal Representative/Guarantor Signature Relation to Patient