

**Authorization for Use and Disclosure of Protected Health Information
MedStat**

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security # _____ Telephone: _____

Information To Be Released - Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Pathology report	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results/reports	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> X-ray films / images
<input type="checkbox"/> Operative report	<input type="checkbox"/> Emergency room record	<input type="checkbox"/> Itemized bill

Other, (specify) _____

Purpose of Request

<input type="checkbox"/> Treatment or consultation	<input type="checkbox"/> At the request of the patient	<input type="checkbox"/> Billing or claims payment
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Other, (specify) _____

Person Authorized to Receive Information

By: Mail Telephone Fax Personal pick-up

Name: _____

Address: _____

Identity of Recipient Verified via: Photo ID Matching Signature Other, specify _____

_____ Verified by: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: Yes No _____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check One: Yes No _____ Initials

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Kosciusko Community Hospital; 2101 E. DuBois Drive, Warsaw, IN 46580. Unless revoked, this authorization will expire on the following date (not to exceed 60 days) or event _____. If no date is set forth this authorization, it will expire 60 days from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that MedStat may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize MedStat to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify _____

_____ Verified by: _____