Authorization to Release Protected Health Information (PHI)

Name:	Birth date:	Last 4 digits of SSN:
Address:	Telephone:	

I AUTHORIZE THE RELEASE OF RECORDS

❑ TO: ❑ FROM:	❑ TO: ❑ FROM:
___Logansport Memorial Hospital (hospital records) ___Logansport Memorial Physician Network (office records) Facility Name: _____ Address: _____ _____	Name:_____ Facility: _____ Address:_____ _____ Telephone:_____ Fax: _____ Email: _____

REASON FOR RELEASE: ** This request is valid for 60 days **

___Personal ___Health Care __Legal ___Other

Copies of the following records may be released as requested:

Format: ❑ Paper ❑ Password protected Flash Drive ❑ Unsecure Email (Disclaimer: Patient understands risk of unsecure email.)

❑ All healthcare information including any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by facility named above. Dates of service: _____

❑ Limit disclosure to all health care information, EXCLUDING any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by facility named above. Dates of service: _____

❑ Occupational record for accommodation determination

❑ Media ❑ Educational Purposes ❑ Marketing use or disclosure

❑ Marketing use or disclosure and LMH is receiving either direct or indirect payment from a third party

❑ Other (Please specify) _____

For infant photograph and details: ❑ LMH Website ❑ Lobby Screen ❑ Electronic Message Board

Important Information About Your Rights

- I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it.
- I understand that when this information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by the recipient and may no longer be protected.
- I understand that I need not sign this form in order to assure treatment.
- I agree to pay the facility the actual cost incurred by the facility for preparing copies of the requested information (if applicable).
- I may request a copy of this signed authorization.
- I understand, when applicable, that the facility named above will receive direct or indirect payment from or on behalf of a third party whose product or service is being described.
- I understand, when applicable, that this information shall be released for the specific purpose of allowing my employer to determine whether I am capable of performing the essential functions of my position, with or without reasonable accommodation. The information disclosed may be shared with my employer in a confidential manner consistent with the provisions of the Americans with Disabilities Act (ADA).
- I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

I, the undersigned, have read the above and authorize the facility named above to disclose such information as herein contained.

_____ _____

Signature of Patient or Legal Representative **Date**

Relationship to Patient: ❑ Parent/Legal Guardian ❑ Spouse ❑ Executor of Estate of Deceased ❑ Power of Attorney ❑ Authorized Legal Representative

Identity verified through Government issued ID by: _____ (please sign or initial)

1101 Michigan Ave. Logansport, IN 46947

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION