MADISON COUNTY HEALTH CARE SYSTEM

An Affiliate of MERCYONE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Madison County Health Care System. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the organization.

PATIENT IDENTIFICATION	Name (Last, First, Middle initial): _____ Date of birth: _____ Last 4 digits of Soc. Sec. #: _____ Any previous names under which records may be kept: _____ Telephone number where we can reach you if we have questions: (_____) _____
PROVIDER (Who is to disclose the information?)	☐ Madison County Health Care System (Hospital) ONLY ☐ Health Trust Physicians Clinic / Earlham Medical Clinic ONLY ☐ Hospital AND clinic records ☐ Other entity (please specify): _____ Street address: _____ City, State, Zip: _____
RECIPIENT (Who is to receive the information?)	Name: _____ Street address: _____ City, State, Zip: _____ Telephone number: (_____)_____ Fax number (if applicable): (_____)_____
PURPOSE OF RELEASE (Check all that apply)	☐ At request of the patient (or legal representative) ☐ Transferring medical care ☐ For claims processing purposes (e.g., third-party liability claims) ☐ Other (please specify): _____
INFORMATION (What information should be released?) (Check all that apply)	☐ Records dating from: _____ to: _____ ☐ Immunization records ONLY ☐ Radiology reports, dates: _____ ☐ Lab visits, dates: _____ ☐ Other (please list specific records): _____

I understand that information to be released may include material that is protected by Federal and/or State law concerning mental health, substance abuse treatment, AIDS-related information and genetics, unless I specifically deny the release by initialing the category below:

Please initial beside any category you do NOT want to be released: Substance abuse (drug or alcohol) _____ Genetics _____
Mental Health information _____ AIDS-related information, diagnosis & test results _____

I understand my healthcare and payment for my healthcare will not be affected by this authorization.

Signature of patient or legal representative: _____ Date: _____

Relationship to patient, if signed by legal representative: _____

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse treatment records or by state law for mental health records, federal requirements (42 CFR Part 2) and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse treatment or mental health information.