Southern Indiana Community Health Care

Paoli- PO Box 270, Paoli, IN 47454, Ph. 812-723-5436, Fax-	Valley – PO Box 123, West Baden, IN 47469, Ph. 812-936-2425, Fax-
Marengo – 5604 E White Oak Ln, Marengo, IN 47140 Ph. 812-365-3221, Fax -	English – 307 S. Indiana Ave, English, IN 47118 Ph. 812-338-2924, Fax -

Authorization to Release Health Care Information

Patient's Name: _____ DOB: _____ SSN: _____

Address: _____ Phone: _____

I hereby authorize release of information:

☐ **To Myself:** I request SICHC, Inc. to release my protected health information to **myself** to the address listed above.

☐ **To SICHC** from address below (Prefer electronic transfer to direct address)

Direct Address: yolandayoder@sichc.allscriptsdirect.net shannondooley@sichc.allscriptsdirect.net
stephaniefrye@sichc.allscriptsdirect.net kathrynpoole@sichc.allscriptsdirect.net
melissaray@sichc.allscriptsdirect.net seansales@sichc.allscriptsdirect.net

☐ **From SICHC**, Inc. to the address or fax below

Hospital/Office Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Record Preferences: ☐ Electronic ☐ Paper **(request >100 pgs. Will be electronic)**

☐ Problem List & Med List ☐ Mammo, Pap, Colon ☐ Entire Record ☐ Billing Information

☐ Last _____ Year(s) of Office Visits ☐ Last _____ Year(s) of Labs and Diagnostic Tests

☐ Other_____ Dates: _____

***If this request is to send records to another health care provider, is this a change in your primary care doctor? If yes, please initial for the change to be applied in your medical record.**

To authorize the release of mental/behavioral health records, in addition to medical records, a separate Authorization for Release of Medical Records must be completed.

Reason for Disclosure:

☐ Continuation of Care/Transfer of Care ☐ Attorney/Legal ☐ Insurance Company

☐ Workman's Compensation ☐ Other: _____

I understand that I may revoke this release at any time in writing. This request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever comes first. I also understand that this release alcohol and/ or substance abuse information. I also understand that HIV, AIDS, and/or any STD might also be released. My signature below indicates my understanding that once my medical records have been transferred to another office I will no longer be considered a patient of SICHC. If at a later date I choose to return I will be scheduled according to the "New Patient" scheduling criteria. I understand that it will take at least 48 hours to process this request.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

☐ Patient Identification Verified. _____ Date Printed/Faxed/Mailed. Signature_____

☐ Patient Identification Verified _____ Date Personnel Verifying Pickup: _____

This request serves as a legal and binding document