Proudly Serving Four (4) Locations:
Comprehensive Health Care, Paoli 812.723.3944 **(F) 812.723.7989 or (F)812.723.7128**
PO Box 270, Paoli, IN 47454
Yolanda Yoder, MD, Sean Saleś, MD, Shannon Dooley, FNP, Stephanie Frye, FNP, Kathryn Poole, FNP, Melissa Ray, FNP
Crawford Family Health, Marengo 812.365.3221 **(F) 812.365.2358**
5604 E. White Oak LN, Marengo, IN 47140
Curtis Thill, MD, Melissa Ray, FNP
Patoka Family Health, English 812.338.2924 **(F) 812.338.3706**
307 S. Indiana Ave., English, IN 47118
Jennifer Shafer, FNP, Kathryn Poole, FNP
Valley Health, West Baden 812.723.7125 **(F) 812.936.2599**
8163 W. ST RD 56, Suite A, W. Baden, IN 47469
Karren Farris, MD, Brittany Stout, FNP, Bekah Berry, FNP

Authorization to Release Health Care Information

Patient's Name: _____ DOB: _____SSN: _____

Address: _____ Phone: _____

I hereby authorize release of information:

□ To release healthcare information of the patient named above **To the SICHC Location**_____
****see above fax number for each requested location and to Mail large requests.**

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

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

Hospital/Office Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Record Preferences: □ Electronic □ Paper **(out-going requests of >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 later, 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