SOUTHERN INDIANA Community Health Care

PAOLI · MARENGO · WEST BADEN · ENGLISH · SHOALS · SALEM · BEDFORD · MITCHELL

RELEASE OF MEDICAL RECORDS

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