SOUTHERN INDIANA Community Health Care

PAOLI · MARENGO · WEST BADEN · ENGLISH · 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:

** To Fax requests or Mail large requests, see next page for Location information and details.

☐ 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 listed 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 ☐ Billing Information

☐ Last Two Year(s) Office Visits ☐ Last Two 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

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RELEASE OF MEDICAL RECORDS
**SUBMISSION INFORMATION

Southern Indiana Community Health Care - Paoli
Comprehensive Health Care
PO Box 270, Paoli, IN 47454
Phone (812) 723-3944
Fax (812) 723-7989 or (812) 723-7128

Yolanda Yoder, MD · Sean Saleś, MD
· Shannon Dooley, FNP · Kathryn Poole, FNP

Southern Indiana Community Health Care - Marengo
Crawford Family Health
5604 E. White Oak LN, Marengo, IN 47140
Phone (812) 365-3221
Fax (812) 365-2358

Curtis Thill, MD · Kelsey Trueblood, FNP

Southern Indiana Community Health Care - English
Patoka Family Health
307 S. Indiana Ave., English, IN 47118
Phone (812) 338-2924
Fax (812) 338-3706

Jennifer Shafer, FNP · Jaclynn Thacker, FNP

Southern Indiana Community Health Care - West Baden
Valley Health
8163 W. ST RD 56, Suite A, W. Baden, IN 47469
Phone (812) 723-7125
Fax (812) 936-2599

Karren Farris, DO · Brittany Stout, FNP
· Bekah Berry, FNP

Southern Indiana Community Health Care - Mitchell
2759 State Road IN-37, Mitchell IN, 47446
Phone (812) 992-5440
Fax (812) 992-5441

Melissa Ray, FNP · Kristi Nissley, FNP

Southern Indiana Community Health Care - Bedford
2512 Q Street, Bedford IN, 47421
Phone (812) 675-4470
Fax (812) 675-4469

Carrie Browne, MD · Amanda Bowman, FNP
· Tricia Spoonmore, FNP · Lori Day, FNP

Southern Indiana Community Health Care - Salem
SICHC Women's Health – Salem
1201 North Jim Day Road. Salem IN, 47167
Phone (812) 653-6374
Fax (812) 723-7989 or (812) 723-7128

Melissa Ray, FNP