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

SOUTHERN INDIANA Community Health Care

PAOLI • MARENGO • WEST BADEN • ENGLISH • SALEM • BEDFORD • MITCHELL

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

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

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

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

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

Southern Indiana Community Health Care - Bedford
629 Lincoln Avenue (Lincoln Plaza), Bedford IN, 47421
Phone (812) 675-4470
Fax (812) 675-4469

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

***Submitting Forms**

Submitting forms can be filled out and submitted during your visit (please arrive early and allow time to fill out paperwork prior to your appointment. Or, if you wish to fillout and submit forms prior to your visit, please do so by either faxing them to **(812) 723-7989**, or if you have a smart phone (with decent photo quality), take a picture of the form and send the image(s) via email attachment to: **register@sichc.org**. And in the email, please note your name and contact information in case we have any additional questions.