NEUROPSYCHIATRIC HOSPITAL OF INDIANAPOLIS
6720 Parkdale Place, Indianapolis IN 46254 Phone: 317-744-9200

☐ Mail to Patient
☐ Call patient to pick up
☐ _____
_____
☐ Completed date/initial
_____

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Identification

Patient Name: _____ Date of Birth: _____
Address:_____City_____ State/Zip_____
Telephone #: _____

I request that my protected health information (PHI) from NeuroPsychiatric Hospital of Indianapolis be disclosed to:

Recipient Name: _____

Address:_____City_____ State/Zip_____ Phone _____
Disclosure Format (Paper is default if not marked): ☐ US Mail – paper ☐ Fax (Healthcare provider only) _____

I authorize the following PHI to be released from my medical record(s):

☐ Abstract / Summary (Includes Discharge Summary, History & Physical, Consultations, Test Results)
☐ Test Result(s) of: _____ ☐ Medication Records ☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No Dates**:** _____
HIV Testing and Results ☐ Yes ☐ No Dates**:** _____
Mental Health ☐ Yes ☐ No Dates**:** _____

Covering the period of healthcare from: Specific Date(s): _____ to _____ **OR**
☐ All past, present and future encounters/visits.

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continued Care ☐ Other (Specify below):
_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Department at the following address: NeuroPsychiatric Hospital of Indianapolis, 6720 Parkdale Place, Indianapolis, IN, 46254. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____.
  If I fail to specify an expiration date/event/condition, this authorization will expire six (6) months from the date of this request.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- **Re-disclosure of Drug and/or Alcohol Abuse Patient Records:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CRF part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Patient or Authorized Representative Signature **Date**

_____ _____
Print Name **Relationship to Patient (if applicable)**

For Office Use Only: Account Number: Medical Record Number: