

**PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

Mail to Patient  
 Call patient to pick up  
 \_\_\_\_\_  
\_\_\_\_\_  
 Completed date/initial  
\_\_\_\_\_

**Patient Identification**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Telephone #: \_\_\_\_\_

**I request that my protected health information (PHI) from NeuroBehavioral Hospital 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: Neurobehavioral Hospital, 9330 Broadway, Crown Point, IN 46307 . 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 CFR 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: \_\_\_\_\_