Name of Patient	Last 4 digits SSN# or Medical Record #
Date of Birth	Phone Number
Address	City, State, Zip

I hereby authorize **REID HEALTH/REID HEALTH PHYSICIAN ASSOCIATES** to release or obtain the below information contained in my medical record to/from:

Name / Address of Person / Organization

PURPOSE OF DISCLOSURE:

☐ Transfer of Care ☐ Personal ☐ Insurance/Billing ☐ Legal ☐ Employment ☐ Compliance with Court
☐ Collaboration with School ☐ Confirmation of Referral ☐ Other:_____

SPECIFIC INFORMATION TO BE DISCLOSED: ☐ Entire Record

☐ Discharge Summary	☐ Pathology Report	☐ Emergency Room Report
☐ History and Physical	☐ X-Ray Result	☐ Medications
☐ Consultation Report	☐ Laboratory Result/Drug Screening	☐ Employer Requested Treatment/Test
☐ Operative Report	☐ Diagnostic Result	☐ Discharge/Aftercare Plan
☐ Immunization/Health Record	☐ Psychological Test Results	☐ Classroom Behavior/Assessment
☐ Psychiatric Evaluation/Treatment	☐ Substance Use Disorder Diagnosis	☐ Substance Use Disorder Treatment
☐ Assessment	☐ Diagnostic Impression	☐ Treatment Summary
☐ School Eval Reports, Grades, Discipline Records	☐ Functional Behavioral Assessments, 504 Plans, Treatment Plans, Disability Determination	☐ Billing/Claim Information ☐ Other: _____

DATES OF SERVICES:

☐ All (only applicable for dates on or prior to the date of this authorization).
☐ _____ (specific date(s) of service)

EXPIRATION DATE or EVENT: _____

I authorize the release of the above information relating to my general medical treatment and/or any treatment relating to alcohol/drug abuse, mental illness, psychiatric treatment, developmental disabilities, HIV/AIDS, Gonorrhea, Hepatitis (viral), Syphilis, Chancroid, Chlamydial infections, Lymphogranuloma Venereum or Genetic Testing. I further authorize the information to be faxed or electronically sent.

I understand this authorization may be revoked at any time, providing the information has not already been disclosed. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I also understand that once the above information has been disclosed per my instruction, the information many no longer be protected by the confidentiality laws. Unless otherwise specified or revoked, this authorization will expire in 60 days unless the disclosure is to myself which will automatically expire 60 days from the date of my signature on this form.

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in regulations.

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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to a publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12 (c) (5) and 2.65.

I hereby state that I have read and fully understand the above statements.

Date	Signature of Patient or Legal Representative	Driver's License / Other ID
Relationship to Patient, if signed by Legal Representative		Signature of Witness

☐ Durable Health Care Power of Attorney – attending physician has declared patient incapable of consent.

REID HEALTH
Richmond, IN 47374 (765) 983-3000
Authorization to Release/Obtain Medical Information

PATIENT LABEL