MGH 23653

MARION GENERAL HOSPITAL
Marion, Indiana

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Patient's Name **Patient's Address**

_____
City, State, Zip Code

_____ _____ _____
Telephone Number **Date of Birth** **Social Security Number**

The undersigned hereby authorizes MGH (Marion General Hospital, Inc) to release the following portions of the medical record(s) of the above named patient during the time period of:

_____
(approximate dates)

Facility where services were provided:
☐ **MGH** ☐ **MGH Physician Practices** _____
Provider Name

_____ **Discharge Summary** _____ **Laboratory Report(s)** _____ **Emergency Treatment**
_____ **History & Physical** _____ **X-Ray Report(s)** _____ **Other** _____
_____ **Operative Report** _____ **Pathology Report** _____

Patient requests records to be prepared by: ☐ **Paper** ☐ **Electronic (CD)**

RELEASE THIS INFORMATION TO:

_____
Name of person, physician, attorney, hospital, clinic or institution

_____ _____ _____
Address of above City, State, Zip Code

THE MEDICAL RECORD IS REQUESTED FOR THE FOLLOWING PURPOSE:

_____ **Attorney** _____ **Insurance**
_____ **Continued Medical Treatment/Follow-up** _____ **At the request of the individual**
_____ **Workmen's Compensation Claim** _____ **Disability**
_____ **Employer** _____ **Other:** _____

I understand that I may REVOKE this release at any time, by writing to Marion General Hospital's Privacy Officer, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I also understand that this release may include medical records of treatment for *physical and/or emotional illness, including treatment of alcohol or drug abuse*. I also understand that *HIV, AIDS or AID-related and/or communicable disease* information may also be released. I also understand the released information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy law.

_____ _____
Signature (Designated by Law) **Date of Signature**

_____ _____
Relationship (If other than patient) **Witness**

Call Taken By: _____ **Date Request Ready:** _____ **Request Completed By:** _____
Contacted By: _____ **Date Contacted:** _____ **Amount Charged:** _____
Released By: _____ **Date Released:** _____

Chart Incomplete: Please initial _____

Health Information Management (HIM), 500 North Wabash Avenue, Suite 112, Marion, IN 46952-2690, Telephone Number 765-660-6060