Independence
HEALTH SYSTEM

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. **I hereby authorize the following Independence Health System Facilities (please check all that apply):**

   □ Butler Memorial Hospital □ Clarion Hospital □ Butler Medical Providers (list each physician/office):

   _____

   To release information from the record of:

   _____ _____
   Patient Name **Date of Birth**

   _____ _____
   Name of Facility/Person **Address**

   Phone: _____ **Fax (Healthcare Only):** _____

2. **Records are requested for the purpose of (check one):**

   □ Medical Treatment/Continued Care □ Insurance □ Legal
   □ Other (Specify): _____

3. **Disclosure Format**: □ Paper Copies □ Electronic Media (unencrypted)

4. **Date(s) of Service:** _____

5. **Specific Information to be Released (check all that apply):**

   □ Discharge Summary □ History & Physical □ Consultation Report(s)
   □ Radiology Report(s) □ Cardiology Report(s) □ Operative Report(s)
   □ Emergency Room Report(s) □ Laboratory Report(s) □ Pathology Report(s)
   □ Pathology Slides □ Radiology/Cardiology Images □ Progress/Office Note(s)

   □ Other (Specify): _____

6. HIV, Mental Health, and Drug & Alcohol Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.
   Do not release: □ HIV □ Mental Health/Psychiatric □ Drug & Alcohol

7. I understand that this authorization is effective for a six (6) month period from the date of signature unless otherwise specified. I understand that I may revoke this authorization in writing at any time except to the extent that Independence Health System or its affiliates or their respective employees or agents have acted upon this authorization. My written revocation must be submitted to the Privacy Officer, Independence Health System.
   See side two of this form for additional patient rights and responsibilities.

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

*Status of Authorized Representative (Proper Paperwork Required):
□ Parent/Legal Guardian □ Power of Attorney □ Next of Kin □ Executor/trix of Estate

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VERBAL AUTHORIZATION (For persons physically unable to sign)

Reason Patient Unable to Sign Consent: _____

NOT Applicable to HIV or Drug & Alcohol Treatment Information. I witness that the patient understood the nature of this release and freely gave their oral authorization. Two Witnesses Required.

_____ _____
Witness Signature **Date/Time** **Witness Signature Date/Time**