ORTHOINDY HOSPITAL
MAIN • SOUTH • WEST

Authorization to Release/Obtain Patient Health Information

_____ Release medical information from OI and/or OIH

_____ Obtain medical information from another facility

For OrthoIndy Physician: _____

Patient Name: _____ Date of Birth: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby request that: **OrthoIndy (OI)**, 8450 Northwest Blvd., Indianapolis, IN, 46278 and/or
OrthoIndy Hospital (OIH), 8400 Northwest Blvd., Indianapolis, IN, 46278
release or obtain my health information in accordance with State and Federal privacy guidelines, as described below.

1. The confidential medical information may be released to or obtained from the following individual or organization.

   Name or Organization: _____ Attn: _____

   Address: _____ City: _____ State: _____ Zip: _____

   Telephone Number: _____ Extension: _____ Fax: _____

2. Information to be released:

   ☐ Office Visits/Status Reports ☐ Itemized Billing Statement ☐ Operative/Injection Reports
   ☐ Hospital Discharge Summaries ☐ Lab Results ☐ Physical Therapy Reports
   ☐ Radiology/MRI Reports ☐ Entire record ☐ Other Info: _____
   ☐ Radiology Films/Digital Images

3. In addition, the following health information may be released or obtained from my health record: ☐ **Yes** ☐ **No**
   - Information that may relate to treatment and/or history of psychiatric or mental health problems
   - Information related to dangerous communicable diseases, including AIDS, HIV and other infections
   - Information regarding treatment for chemical dependency

4. Service date(s) to be released: _____

5. Purpose of disclosure: ☐ Treatment of Patient ☐ Insurance Request ☐ Other: _____
   ☐ The patient has an upcoming appointment with a physician on (date): _____ /_____ /_____

This release shall apply to any and/or all data listed above unless otherwise indicated by the patient as follows. Do not release information contained in my health record regarding: _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. I further understand this information may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy guidelines.

This authorization is valid for sixty (60) days after the date of this request is made unless a different date, event or condition that would cause this authorization to expire sooner is indicated as follows: _____

I acknowledge, by signing this authorization that there may be a charge for copies of my health information as allowed by State and Federal laws. If OI and/or OIH sends records directly to another physician for treatment continuity, there is no charge. There may be a charge for all other requests.

I understand that I may contact a representative at OI at (317) 802-2000 or OIH at (317) 956-1000 regarding any questions.

_____ _____/_____/_____ _____:_____ a.m. p.m.
Patient or Patient Representative Signature — Date — Time

_____ _____
Printed Name of Patient or Patient Representative — If Patient Representative, Relationship to Patient

_____ _____/_____/_____ _____:_____ a.m. p.m.
Witness Signature/OrthoIndy Representative — Date — Time

HIM: If applicable, check the box and forward this form for review. ☐ OrthoIndy ☐ OIH