1. I hereby authorize: ❑Parkview Regional Medical Center ❑Parkview Hospital Randallia ❑Park Center
❑Parkview Bryan Hospital ❑Parkview DeKalb Hospital ❑Parkview Huntington Hospital
❑Parkview Kosciusko Hospital ❑Parkview LaGrange Hospital ❑Parkview Montpelier Hospital
❑Parkview Noble Hospital ❑Parkview Ortho Hospital ❑Parkview Wabash Hospital
❑Parkview Whitley Hospital ❑Parkview Physicians Group (practice type):_____
❑Other: _____

to release my information to: Name: _____

Address:_____ City:_____ State:____ ZIP:_____

Phone Number:_____ Method of Delivery:_____

2. Patient's Full Name:_____ Date of Birth: _____

Address:_____ City:_____ State:____ ZIP:_____

Phone Number:_____ E-mail:_____

3. The purpose for which the following information is being requested:_____

4. I authorize the following information to be released from my medical/surgical records:

Date(s) of Service(s): _____

Records authorized to be released are listed below. In the event that the information checked below includes reference to a mental health or drug and/or alcohol condition, treatment, or diagnosis, I authorize the release of that information.

Please check (✓) the appropriate item(s):

❑ER Record/Dictation	❑History and Physical	❑Progress Notes	❑Consultation(s)	❑EKG(s)
❑Discharge Summary	❑Surgery Report(s)	❑Labs (incl. HIV)	❑Imaging Report(s)	❑M.D. Office Visit
❑Pathology Report	❑Doctors Orders	❑Medications	❑Imaging Films	❑UB-92 or Itemized Bill
❑Genetic Screening/Testing	❑Photographs, Video Tape, Digital or Other Images			

❑Other (Please Specify):_____

To authorize the release of mental/behavioral health records, in addition to medical/surgical records, a separate Authorization For Release of Behavioral Health Records must also be completed.

5. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon this authorization. If not previously revoked, this authorization will terminate on the following date, event or condition:_____. If no date, event or condition specified, this authorization will expire after 60 days.

I further understand that I will agree to pay the facility the costs incurred by Parkview Health in preparing the copy of the requested medical records as allowed by State and Federal guidelines, including the additional cost of the electronic media device (if applicable).

I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

I understand that I am entitled to a copy of this authorization.

Printed Name:_____

Patient/Parent/Guardian/Legal Representative Signature:_____ Date:_____ Time:_____

Relationship to Patient: ❑Self If other than self, must specify:_____

FOR FACILITY PERSONNEL ONLY

❑Patient Identification Verified. Signature:_____ Date:_____ Time: _____

Hospital Personnel Receiving Form

All entries must be dated and timed.

Patient Name: _____

Medical Record Number:_____

Date of Service:_____

PARKVIEW

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS