INDIANA HEALTHCARE PHYSICIAN SERVICES
PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Information to be released to:
Name: ____________________________
Address: ___________________________
____
Phone: ____________________________

Name of Patient:___________________________
Address: _______________________________
____
____
Birth date:_______________________________
Phone: _______________________________

I authorize ____
Name Phone #
to release my health information including records concerning psychiatric, behavioral, alcohol and drug abuse, sexually transmitted disease and HIV related information for the purpose of:
____
(Continuity of care, disability determination, insurance claim. legal matter, my personal records, etc.)
Type of Information to be released (must be specific)
____

I understand the following:

- That I may inspect or copy the protected health information described by this authorization.
- That this authorization may be revoked in writing and delivered to the contact person at the office, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- That information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- That Indiana Healthcare Physician Services shall not condition treatment, payment or enrollment in their facilities on my providing authorization for the requested use of disclosure.
- If the only reason I have asked IHPS to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this Authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this Authorization permitting us to disclose the results to your employer. Otherwise, your ability to receive treatment, payment, and enrollment in a plan or eligibility for a benefit does not depend on your signing this form.

This Authorization expires:
___ On the following date: _ _ / _ _ / _ _ (If no date or event is stated, expiration is 90 days from the date it was signed.
___ When the following event occurs: ____

_________________________________ _______________________________
(Signature of Patient or Patient Representative) Relationship

_________________________________ _______________________________
Witness Date

The above individual is unable to consent because (check one):

___Minor ___Incompetent ___Other (explain): ________________________