1. I hereby authorize:
   - ❑ Parkview Regional Medical Center
   - ❑ Parkview Hospital Randallia
   - ❑ Park Center
   - ❑ Parkview DeKalb Hospital
   - ❑ Parkview Huntington Hospital
   - ❑ Parkview LaGrange Hospital
   - ❑ Parkview Noble Hospital
   - ❑ Parkview Ortho Hospital
   - ❑ Parkview Wabash Hospital
   - ❑ Parkview Whitley Hospital
   - ❑ Parkview Behavioral Health
   - ❑ Parkview Physicians Group (practice type): ______________________
   - ❑ Other: ______________________

   to release my information to: Name: ______________________

   Address: ______________________

2. Patient's Full Name: ______________________

   Address: ______________________

   Telephone Number: ______________________ Date of Birth: ______________________

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

4. I authorize the following information to be released from my mental/behavioral health records:

   Date(s) of Service(s): ______________________

   Mental Health and/or Drug and Alcohol Treatment Records that are authorized to be released:

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

❑ History and Physical	❑ Psychosocial Assessment	❑ Medications	❑ X-Rays
❑ Psychiatric Eval/Tests	❑ Psychosocial Eval/Tests	❑ Psychological Testing Results	❑ EKGs
❑ Progress Notes	❑ Physician Orders	❑ Alcohol/Drug Assessments	❑ Labs
❑ Discharge Summary	❑ Treatment Plan	❑ Alcohol/Drug Treatment Records	❑ Electronic Release
❑ Group Therapy Notes	❑ Psychotherapy Notes	❑ Other (Please Specify): ______________	

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

5. I understand that I may revoke this authorization at any time, 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 mental/behavioral health 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, except for drug and alcohol treatment information.

   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: ______________________

FOR FACILITY PERSONNEL ONLY

❑ Patient Identification Verified. Signature: ______________________ Date: __________ Time: __________

Hospital Personnel Receiving Form

NOTE: Important notices about legal requirements for the treatment of mental/behavioral health records, including drug and alcohol treatment records, are on the back of this form.

All entries must be dated and timed.

AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH RECORDS

Patient Name: ______________________

Medical Record Number: ______________________

Date of Service: ______________________

White - Chart Yellow - Requestor

HIMROI

NOTICE

If the attached records contain information regarding mental health and/or drug and alcohol treatment please read and follow the information presented below.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains to or as otherwise written permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The regulations also have the following restrictions and requirements.

Statutory authority for confidentiality of drug/alcohol abuse patient records (42 CFR Section 2.1)

a. Disclosure authorization - Identity, diagnosis, prognosis or treatment of any patient may not be disclosed except for purposes under subsection (b)

b. Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent -
   1. May be disclosed in accordance with prior written consent of the patient . . .
   2. Whether or not the patient has given written consent, the content of such record may be disclosed as follows:
      a. To medical personnel to the extent necessary to meet a **bona fide medical emergency.**
      b. To qualified personnel for purpose of scientific research, audits, or program evaluation, but identity of patient may not be disclosed in any manner.
      c. If authorized by appropriate court order of competent jurisdiction - after showing good cause - the record may be disclosed as ordered by the court.
   3. A minor patient's authorization may be required for disclosure, even to his or her parent, guardian or other legal representative.

c. Armed Forces and Veterans' Administration: interchange of records; report of suspect child abuse and neglect to State or local authorities - The prohibitions of this section do not apply to any interchange of information with the above named organizations.

Medical Emergencies (42 CFR Section 2.51):

a. General Rule - Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about the patient for the purpose of treating a condition which **poses an immediate threat to the health of any individual and which requires immediate medical intervention.**

b. Special Rule - Release to FDA because of health threat from product manufacturing, labeling or sale error.

c. Procedure - Immediately document in patient record: 1. The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility; 2. The name of the individual making the disclosure; 3. The date and time of the disclosure; and 4. The nature of the emergency (or error if report was to FDA).

Indiana Code (Release of Mental Health Records to Patient and Authorized Person I.C. 16-39-2-1 – I.C. 16-39-2-12):

Confidentiality - Disclosure A patient's mental health record is confidential and shall be disclosed only with the consent of the patient unless otherwise provided in the following:

1. This chapter (I.C. 16-39-2-1 – I.C. 16-39-2-12)
2. I.C. 16-39-3 (Release in investigations and legal proceedings)
3. I.C. 16-39-4 (Provisions of mental health information)
4. I.C. 16-39-5 (Use of original health record for legitimate business purposes)

Additionally ALL medical records are protected by the Health Insurance Portability and Accountability Act (P.L. 104-191 (1996) and regulations promulgated there under) and Title 16, Article 39 of the Indiana Code.

AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH RECORDS

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