PATIENT INFORMATIIOON	Name _____ Date of Birth _____/_____/_____ Address _____ Daytime Phone _____ City _____ State _____ Zip _____ Previous Name _____
Who do you authorize to RELEASE your records: (Who has the information you want released?)	Scottsburg Family Healthcare Phone 812-752-1151 PO Box 290 Scottsburg, IN 47170
Who do you authorize to RECEIVE your records: (Where do you want the information sent?)	Name _____ Phone _____ Address _____ Fax _____ City _____ State _____ Zip _____ Circle if **SFHC**, address as above.
Information to be Released: (What do you want sent or released? Circle the appropriate options.)	Date(s) of Service: From _____/_____/_____ To _____/_____/_____ Any and all records (includes ALL types of records listed below). <u>Only record types circled below:</u> Office visits/Progress notes — Admit history and physical — Operative reports Laboratory reports — Discharge summary/note — Pathology reports Radiology reports — Emergency room record — Billing records Immunization records — Consultations — Treatment plan Other records (specify types):
Special Authorization Section: ((Do you want this type of information sent or released? Circle the appropriate options.)	State and federal law protect the following information. If this information applies to the patient, please indicate if you want this information released by this office or obtained from another office (include dates where appropriate). Alcohol/Drug treatment information Yes No HIIVV/AIDS-related information Yes No Mental Health information Yes No Genetic testing information Yes No
Release Instructions:	Records will be released in electronic format on a thumb drive. If the patient is requesting them for themselves, include a check for $6.50. This is the amount allowed by Indiana law.
Purpose of Release: (Why is it needed?)	Continuing medical care^ — Personal use* — Insurance application* Transfer of care^ — Lawyer/legal* — Disability determination* Other** _ ^Records released directly to a provider or clinic is free of charge for first copy. *Fees charged in accordance with IN statute 16-39-9-3 and Federal Rule 45 C.F.R. § §116644..55244.

- This authorization will expire in 180 days from the date signed unless otherwise specified. Alternate expiration date _____/_____/_____
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to Scottsburg Family Healthcare (SFHC). The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this authorization in order to receive health care treatment.
- SFHC's records may include records that we have received from other organizations. If these records have been used by SFHC, and filed in the record SHFC maintains about you, these records may be released with our SFHC records.
- SFHC cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release SFHC from any and all liability resulting from a redisclosure by the recipient.

Signature of Patient or Legal Representative: (If a legal representative then circle the appropriate options.)	**Signature** _____ Date _____/_____/_____ **Printed name** _____ If a legal representative signs, then patient is a: minor legally incompetent or incapacitated deceased Legal authority of signer: parent legal guardian activated POA for health care next of kin / executor of deceased