THE METHODIST HOSPITALS

Northlake Campus
Corporate Office
600 Grant St.
Gary, IN 46402
(219) 886 – 4000

Southlake Campus
8701 Broadway
Merrillville, IN 46410
(219) 738-5500

AUTHORIZATION FOR ACCESS, USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE NUMBER: _____

I authorize the: ☐ Access ☐ Use ☐ Disclosure of the above named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

☐ Methodist Hospital Southlake
8701 Broadway
Merrillville, IN 46410

☐ Methodist Hospital Northlake
600 Grant Street
Gary, IN 46402

☐ Other _____
_____
_____
Phone: _____

The type and amount of information to be accessed, used, or disclosed is as follows: (include dates)

☐ Test Results (please specify) _____
☐ Pertinent parts/abstract of medical records _____
☐ History and Physical _____
☐ Discharge Summary _____
☐ Consultation(s) _____
☐ Other _____

I understand that my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ I agree
☐ I disagree (If you disagree, please explain) _____

_____

This information may be accessed or disclosed to the following individual or organization: _____

_____

This information is being used for the following purposes:

☐ Continuity of Care ☐ Attorney Request ☐ SSI, Disability, Medicare or Medicaid ☐ Insurance Purposes

☐ Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Medical Records. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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. Unless otherwise revoked, this authorization will expire ***60 days*** from the date of the signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect the information to be accessed, used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. Any questions can be directed to a Manager in Medical Records.

This information is/may be protected under the Federal Confidentiality Regulations CFR 42.

I understand there may be a fee for copying these records in accordance with 45 CFR 164.524 and IC 16-39-9-3.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of witness

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