Memorial
Hospital of South Bend

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED MEDICAL INFORMATION

Place Label Here

PATIENT IDENTIFICATION

PATIENT INFORMATION			
NAME	TELEPHONE ( )	PREVIOUS ADMISSION NAME, IF DIFFERENT	
ADDRESS		BIRTH DATE	MR #
CITY/STATE/ZIP	DATES OF SERVICE FROM ____________ TO ____________		

Person(s) or class of persons authorized to receive the information:

Name: ____________________

Address: ____________________

City/State/Zip: ____________________

Description of information that may be used and disclosed:

- ☐ Entire Chart
- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consult Report(s)
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Operative Report(s)
- ☐ Other: ____________________
- ☐ Abstract only: Discharge Summary, History & Physical, Operative Report, Laboratory, Radiology, Consults, EKGs

The information will be used and disclosed for the following purposes:

☐ Personal Use ☐ Attorney/Legal ☐ Continuing Patient Care ☐ Insurance ☐ Other: ____________

DELIVERY METHOD: ☐ Mail ☐ Patient will pick up when ready ☐ **Review chart in person** ☐ CD

I understand that the health information described above may be disclosed by the recipient and the information may no longer be protected by federal privacy regulations.

I understand that Memorial Hospital of South Bend may receive compensation for the use and disclosure of the information.

I understand that Memorial Hospital of South Bend will not condition my ability to obtain treatment on the provision of this Authorization.

This Authorization request does not apply to any dates of service beyond date of signature.

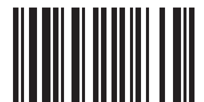
I understand that I may revoke this Authorization in writing at any time by writing to Medical Records Department – Memorial Hospital of South Bend unless action has been taken in reliance upon this Authorization. This Authorization expires 60 days from the date it is signed by me. I understand that the medical information released may contain information concerning treatment of physical and/or emotional illness, drug and/or alcohol abuse, mental health, communicable disease, HIV, AIDS or AIDS-related illness. I understand there is a charge for copying medical records at a fee of $20.00 up to ten (10) pages and $.50 for each additional page, plus postage. These charges do not apply for copies requested for continuing medical care. By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my health information in accordance with the terms of this Authorization.

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE	DATE SIGNED	TIME
NAME OF GUARDIAN OR LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT	

☐ **Check here if you are a Memorial Hospital/Beacon Health System employee.**

☐ Patient was given a copy of this Authorization.

Original - Medical Records **Copy** - Patient



575501

 Reorder from Materials
Form # 575501 A 09/93 MC (Rev. 02/14)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION