Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: ____________________ Date of Birth: ____________________

Street Address: ____________________ Last 4 numbers of SSN: ____________________

City, State, Zip: ____________________ Telephone: ( ) ____________________

Email address: ____________________

Release Information From:

____
(List applicable Facility(s) and/or Practice(s))

____

____
(Phone number) (Fax number)

Release Information To:

Hoosier Services Inc.
(Name of facility, person, company) (Relationship)

18032 Lemon Dr, Ste C-618 Yorba Linda CA
(Street Address or PO Box, City, State, Zip Code) 92886

800.882.4156 fax 800.882.4957
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☒ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other____________________

Fill in dates of treatment for records to be released:

Treatment dates: From ____________________ **To** ____________________

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):
- ☐ Hospital Summary
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation reports
- ☐ Operative Reports
- ☐ Laboratory reports
- ☐ Radiology/X-Ray Reports
- ☐ Pathology reports
- ☐ Emergency Record
- ☐ Cardiac Reports/EKG
- ☐ Other____________
- ☐ Entire record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):
- ☐ Office/Clinic Summary
- ☐ Office Visits
- ☐ Physical Exam
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Other____________
- ☐ Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):
- ☐ Hospital Summary
- ☐ Assessments
- ☐ Discharge Summary
- ☐ Physician Orders
- ☐ Progress notes
- ☐ Medications
- ☐ Lab reports
- ☐ Other ____________
- ☐ Entire Record (Not including psychotherapy notes)

FORMAT:
- ☒ CD (charges may apply)
- ☒ Email Address noted above, where permitted
- ☐ Paper copy (charges may apply)
- ☐ Other____________

DELIVERY METHOD:
- ☐ Reg.US Mail ☐ Pick-up ☒ Fax, where permitted
- ☐ Overnight/Express Mail Service, where permitted
- ☒ Secure email
- ☐ Other: ____________

PATIENT'S RIGHTS – I understand that:
- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless another date or event is written here: ____________

Signature: ____________ **Print Name:** ____________ **Date:**____________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** ____________

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor:____________ **Print Name:** ____________ **Date:** ____________

Authorization given to patient / Date of release:____________via ☐Mail ☐Fax ☐Other____________ ☐**ID Verified** ☐**DL/Other ID**____________
CHS Employee Name & Title: ____________**CHS Employee Signature:** ____________**Date:**____________

Patient Information or Sticker

Name:
DOB:
Medical Record #:
Account #: