FACILITY: ☐FSRMC ☐PMC ☐LCMC ☐FLMC ☒MMC ☐RMC ☐MHHS

Covenant HEALTH

AUTHORIZATION TO RELEASE HEALTH INFORMATION

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I, _____, hereby authorize Methodist Medical Center (the "Hospital") to disclose health information regarding the following patient:

Patient Name: _____ Date of Birth: _____
Address: _____ Patient's Phone: _____
_____ Social Security No.: _____
Phone: _____ Date of Death: _____

1. The information is to be disclosed to the following persons or organizations:
Name: Hoosier Services Inc.
Address: 18032 Lemon Dr.,#C-618, Yorba Linda, CA 92886

2. Purpose. The purpose of the use or disclosure is: insurance-Protective Life

☒ At the request of the patient
☐ Other: _____

If the purpose is for marketing, will the Hospital receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*: I **understand that this information may include, but not limited to, information related to psychiatric or psychological treatment, treatment for drug and/or alcohol use, or information relating to Acquired Immune Deficiency/HIV.**

☐ Entire medical record, other than psychotherapy notes*; OR

☒ The following of the medical record

☒ Discharge summary	☒ Progress notes
☒ Lab results	☐ Photographs, videotapes, or other images
☒ History and physical exam	☐ Mental or behavioral health records
☒ Consultation reports	☐ Psychotherapy notes *
☒ X-ray reports	☐ Genetic test results
☐ HIV/AIDS test results and treatment	☐ Admission notes
☒ Treatment plan	☐ Summary of treatment
☐ Alcohol and drug treatment records	
☐ Other (specify): _____	

* *If the authorization is for psychotherapy notes, it may not request any other part of the medical record.*

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☐ The following billing and payment information:

_____

_____

☐ Other information:

_____

_____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Hospital. However, the revocation will not have any effect on any uses or disclosures the Hospital may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: (A) one year after the date this authorization is signed or (B) on the occurrence of the following event: _____ (e.g., end of research study; final resolution of specified litigation).

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Hospital will not condition treatment on whether I sign this Authorization.

8. Certification. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.

☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.

Signed this _____ day of _____, 20___.

Signature: _____
Print name: _____
Address: _____
_____
Phone No: _____

(ONE COPY TO BE RETAINED BY THE PATIENT)

For Hospital Use Only:

Date received: _____ Expiration date: _____

How was identity verified? _____ Copy made? ☐ Yes ☐ No
How was authority verified?: _____ Copy made? ☐ Yes ☐ No

By: _____ Title: _____ Date: _____