Patient Name: _____

Date of Birth: _____

Use of disclosure: I hereby authorize Hoag Memorial Hospital Presbyterian to disclose the information listed below to: (List the person/organization authorized to receive this information.)

Name/Organization: Hoosier Services Inc.

Address: 18032 Lemon Drive #C-618

City: Yorba Linda State: CA Zip: 92886 Phone: 800.882.4156 fx:800.882.4957

[X] Mail [ ] Patient will pick up

[ ] Family member will pick up: Name: _____ Phone: _____

Requested Media: [ ] Paper [X] CD

This authorization applies to the following:

[ ] All health information pertaining to any medical history, mental or physical condition and treatment received, OR

[ ] Only the following records or types of health information: Date of Service: _____

[ ] ED Records [ ] History & Physical [ ] Consults [ ] Operative Report

[ ] Discharge Summary [ ] MD Progress Notes [ ] MD Orders [ ] Nurse's Notes

[ ] EKG, EMG, EEG [ ] Radiology Reports [ ] Anesthesia Records [ ] Lab/Pathology Reports

[ ] Radiology Film/CD, Type: _____ [ ] Other: _____

I specifically authorize release of the following information (check as appropriate):

[ ] Alcohol/drug treatment information [ ] HIV Test Results [ ] Mental Health Treatment Information

A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose for use/disclosure: [ ] Patient Request [ ] Further Medical Care [X] Insurance OR

[ ] Other: _____

Expiration: This authorization expires (insert date): _____

Signature: _____ Date: _____ Time: _____AM/PM

[Patient/Legal Representative]

If signed by other than patient, indicate legal relationship to patient: _____

Print Name (Legal Representative): _____