Authorization to Disclose Protected Health Information

Release Information To or Receive From:
(*Circle To or From*)

_____
(Name of Individual or Organization)

_____

_____
(Address)

_____
(Fax Number)

Release Information To or Receive From NorthShore Health Centers **(*Circle To or From*)**:

Fax Numbers - Circle One of the Following:

Scottsdale Health Center	(219) 764-5333
Chesterton Health Center	(219) 763-8938
Stacy McKay Health Center	(219) 764-5385
Lake Station Health Center	(219) 962-1863
Hammond Health Center	(219) 844-9099
Merrillville Health Center	(219) 884-2582
Dr. Rivera Dental Center	(219) 962-1189

Phone Number: (219) 763-8112 Ext. _____
Mailing Address: P.O. Box 1430, Portage, IN 46368

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.
Identifying information at the time of service:

Patient's Full Name: _____

Maiden or Other Name: _____

Date of Birth: _____ **Last 4 Number of Social Security Number:** _____

Phone Number: _____

Address: _____

(*Mailing Address, City, State, Zip*)

Covering periods of treatment:

All Dates of Service _____ Or for the specific period of (Date) _____/_____/_____ To: (Date) _____/_____/_____

1. **Information authorized for disclosure (please circle the appropriate boxes)**, if included in my records:
   - ☐ Complete Health Record
   - ☐ Dental Records
   - ☐ Patient Plans
   - ☐ History and Physicals
   - ☐ Progress Notes
   - ☐ Immunization Records
   - ☐ Radiology and Diagnostic Imaging Reports
   - ☐ Photographs, Videos, Digital or Other Images (On CD)
   - ☐ Pathology Reports
   - ☐ Laboratory Tests
   - ☐ Other:_____

2. **If applicable, I also give permission for the following areas of *Sensitive Protected Health Information* to be disclosed (*please circle the appropriate boxes*):**
   - ☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
   - ☐ Behavioral Health Services / Psychiatric Care
   - ☐ History and Treatment for Alcohol and/or Drug Abuse

3. **Manner in which my protected health information is to be disclosed (*please circle the appropriate boxes*):**
   - ☐ Records on paper ☐ Records on CD ☐ Faxed

4. **Purpose for Disclosure (*please circle one*):**
   - ☐ Personal
   - ☐ Legal
   - ☐ Transfer of Care
   - ☐ Coordination of Care
   - ☐ Insurance
   - ☐ Other, specify: _____

5. **I understand that:**
   - I have the right to revoke this authorization at any time, unless NorthShore Health Centers has already released the information on reliance of my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to NorthShore Health Centers.
   - This authorization will expire on _____ (Date).
   - If no expiration date is provided this authorization will be valid for (60) days from the date signed below.
   - Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy standards.
   - 42 CFR Part 2 and/or HIPAA 45 CFR prohibits further re-disclosure of records related to substance and alcohol abuse and treatment.
   - I will not be denied treatment, payment, enrollment, or eligibility for benefits based on signing this Authorization.
   - Northshore Health Centers, its employees, officers, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the information indicated above and authorized herein.

_____ _____

Signed: Patient – (or Legal Representative, Parent, or Legal Guardian) **(Relationship if not Patient)**

_____

Date

Office Use Only

Name and Title of Person Releasing Information: _____

Date: _____/_____/_____