Indiana (HIPAA) Medical Records Release

MOSAIC
Health & Healing Arts

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient Name: _____ **Social Security #:** _____ **Date of Birth:** _____

Previous or other names used: _____

Patient Address: _____

Patient Phone #: _____ **Patient Email:** _____

I authorize the use and disclosure of health information about me as described below:

Facility / Provider

Address

Phone # / Fax #

_____

Agency or Individual(s) Authorized to Release my Health Information:
Mosaic Health and Healing Arts Inc. 330 Lakeview Drive, Goshen, IN 46528
Phone: (574) 537-2680 Fax: (574) 533-0218

Health information that may be used / disclosed is limited to the following:

☐ **Itemized Bill**	☐ **Progress Notes**	☐ **Pathology Reports**	☐ **Lab results/ reports**
☐ **Entire Record**	☐ **Imaging/X-ray reports**	☐ **Operative/Procedure Reports**	☐ **Other** _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

I agree to the release of my medical or billing records containing the sensitive information listed above. ☐ Yes ☐ No

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire ***2 years*** after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage. NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

_____ _____
Patients or Authorized Personal Representative's Signature **Date**

_____ _____
Relationship to Patient/Authority to Act on Patient's Behalf **Interpreter, if utilized**

_____ _____
Witness Signature **Expiration Date or Event**