FRANCISCAN ST. MARGARET HEALTH NORTH
5454 HOHMAN AVE
HAMMOND, IN 46320

FRANCISCAN ST. MARGARET HEALTH SOUTH
24 E JOLIET ST
DYER, IN 46311

I AUTHORIZE FRANCISCAN ST. MARGARET HEALTH TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S).

Patient Name (*PleasePrint*):_____

Patient Address:_____

Date of Birth:_____ Last 4 Digits of Social Security #_____ Patient Telephone #:_____

Covering the period(s) of treatment:_____

INFORMATION TO BE RELEASED:

_____Discharge Summary	_____Radiology (X-ray, CT Scan, MRI)	_____ER record
_____History & Physical	_____EKG	_____Lab Results
_____Operative Report	_____Consultations	_____UB04
_____Complete Health Record	___X___Other (specify): **Please see enclosed Subpoena or Letter Request for information to be disclosed.**	

INFORMATION TO BE RELEASED TO:

Name: **RECORDS DEPOSITION SERVICE, INC.**

Address: **PO BOX 5054**

City, State, Zip: **SOUTHFIELD, MI 48086-5054**

Telephone #: **P: 248-357-3330 F: 248-357-3337**

PURPOSE OF DISCLOSURE: _____Continuation of Care _____Insurance _____Attorney _____Personal Use ___X___Other **For Discovery Before Trial**

I understand this authorization can be revoked by me at any time in writing to (*facility Name)* except that disclosure made in good faith has already occurred in reliance on this authorization. *(facility name)* will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations.

I understand that a fee may be charged for preparing a copy of the requested records. I understand that 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 or state law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____ _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days

Your protected health information will be provided to you in paper format. If you wish for your protected health information to be provided to you on electronic media that meets the HIPAA and HITECH requirements, you must initial here:_____. The password for accessing your electronic media is:_____.

I understand that this release also pertains to records regarding the testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or for psychiatric treatment or counseling or communicable disease, unless I have initialed here:**_____.

SIGNATURE:_____ DATE:_____

RELATIONSHIP TO PATIENT, if other than patient:_____

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable):_____

WITNESS SIGNATURE:_____ DATE:_____

Franciscan
ST. MARGARET HEALTH

Place Patient Label

SMMHC Release of Information Authorization