Release of Information Authorization Form	
Healthcare Location (who has the information you want released, please check specific location)	I AUTHORIZE FRANCISCAN HEALTH TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S). Please select a location _____ Hammond- 5454 Hohman Avenue, Hammond, IN 46320 _____ Dyer- 24 Joliet Street, Dyer, IN 46311 _____Munster- 701 Superior Avenue, Munster, IN 46321 _____ Michigan City– 3500 Franciscan Way, Michigan City, IN 46360 _____ Crown Point – 12750 St. Francis Drive, Crown Point, IN 46307 _____ Crown Point – 1201 S. Main St., Crown Point, IN 46307 _____ Lafayette Central – 1501 Hartford Street, Lafayette, IN 47904 _____ Lafayette East – 1701 S. Creasy Lane, Lafayette, IN 47905 _____ Crawfordsville - 1710 Lafayette Rd., Crawfordsville, IN 47933 _____ Rensselaer- 1104 East Grace Street, Rensselaer, IN 47978 _____ Indianapolis- 8111 S. Emerson Avenue, Indianapolis, IN 46237 _____ Mooresville -1201 Hadley Road, Mooresville, IN 46158 _____ Carmel- 12188 B North Meridian Street, Carmel, IN 46032 _____ Orthopedic Hospital Carmel – 10777 Illinois St. Carmel, IN 46032 _____ Chicago Heights- 1423 Chicago Road, Chicago Heights, IL 60411 _____ Olympia Fields- 20201 South Crawford Avenue, Olympia Fields, IL 60461 _____ Lakeshore ASC, LLC-12800 Mississippi Parkway, Pavilion C, Crown Point IN, 46307
Requesting Access	❑ Are you requesting photocopy images of medical records OR ❑ Are you requesting electronic access to your data. Please note use of this form constitutes a request for records that will require manual effort and therefore result in a charge. Otherwise, you can electronically access your record through your MyChart account.
Patient Information	Patient Name (*Please Print):*_____ Patient Address: _____ Date of Birth: _____ Last 4 Digits of SS #_____Telephone #: _____
Recipient Information (Who may receive the information/ where do you want it sent)	Recipient Name: Records Deposition Service Address/City/State/Zip: P.O. Box 5054, Southfield, MI 48086-5054 Telephone : (248) 357-3330 F (248) 357-3337 E requests@recdep.com
Information To be Released	Date(s) of Service: _____ ❑Billing Records ❑Consultation ❑Discharge Summary ❑EKG ❑ER Record ❑Fetal Monitor Strips ❑History & Physical ❑Immunization Report ❑Lab Results ❑Operative Report ❑Progress Notes ❑Radiology Images ❑Radiology Result ❑ Sexual Assault ❑Complete Health Record (this is the legal medical record as defined by the hospital) ❑Other (specify): _____
Release Purpose	☒Attorney ❑Continuing Care ❑Insurance ❑Personal Use ❑ Other_____

Release Instructions	Release Method/Format (check one) Records will be released in a .pdf format unless specified below. ❑Paper ❑MyChart (patient only) ❑ Fax Number:_____ ☒Email Address: requests@recdep.com ❑CD/DVD ❑USB ❑Other format requested _____ Electronic records are delivered in a secure/encrypted method. However, I have the choice to receive my records in an unsecure/unencrypted format. _____ By initialing here, I understand that unencrypted e-mail or media (e.g., CD, DVD, USB Flash Drive, etc.) is not considered a confidential means of communication. I have been offered a secure method to receive my records and I have chosen to receive without the protection of encryption. I agree to waive any rights that I may have against Franciscan Health, any affiliated organization, or physician, or the suppliers, for any compromised information due to the technical failures and/or unintended breach of confidentiality.
42CFR Part 2 Disclosure Statement	This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit any person other than the one whose information is being requested from making any further disclosure of this records. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65;.

By signing this authorization form, I understand that:

This authorization will expire in 60 days from the date signed unless otherwise specified_____

This authorization can be revoked by me at any time in writing to Franciscan Health except that disclosure made in good faith has already occurred in reliance on this authorization.

The information to be released may include billing and treatment records related to behavior and mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.

Franciscan Health will not condition treatment, payment, enrollment, or eligibility for benefits on whether this authorization is signed except as allowed under the HIPAA regulations.

Fees may be charged in accordance with state statue and federal rule.

SIGNATURE:_____ DATE:_____

RELATIONSHIP TO PATIENT, if other than patient: _____

Department Use only:

Initials of coworker releasing information_____Date_____
Medical Record Number_____CSN_____
Password (if applicable) _____