RELEASE OF INFORMATION TO THIRD PARTY AUTHORIZATION FORM

1. Patient Name (Please Print): _____
   Patient Address: _____
   Date of Birth: _____ Last 4 Digits of SS #_____Telephone #: _____
2. Release to be made to the following person/organization:
   Person/organization Name:_____ Telephone: _____
   Address/City/State/Zip:_____
3. Location(s) where the service was provided – check below:

Franciscan Health Hospital:

❑ Hammond	❑ Lafayette Central
❑ Dyer	❑ Lafayette East
❑ Munster	❑ Crawfordsville
❑ Michigan City	❑ Rensselaer
❑ Crown Point	❑ Indianapolis
❑ Chicago Heights	❑ Mooresville
❑ Olympia Fields	❑ Carmel
❑ Beech Grove	❑ Orthopedic Hosp Carmel

Other Franciscan Services:

- ❑ Independent Diagnostic Testing Facility Carmel
- ❑ Retail Pharmacy; Location_____
- ❑ Home Health; Location_____
- ❑ Hospice; Location_____
- ❑ Durable Medical Equipment
- ❑ Franciscan ExpressCare; Location_____
- ❑ Franciscan Working Well; Location_____
- ❑ Franciscan Health eAccess; Location_____
- ❑ Franciscan Sports Medicine (Healthy Roster for student athletic programs)

❑ Physician/Specialist Office Location: _____
Provider Name: _____
❑ Other _____

4. Include the following date(s) of service:_____
5. Send the following record type(s) – check below:
   ❑ Lab Results ❑ Radiology Results ❑ Cardiology Results ❑ ER Record ❑ Operative Report
   ❑ Progress Notes ❑ Discharge Summary ❑ Immunization Report ❑ History & Physical ❑ Consultation
   ❑ Discharge Instructions/After Visit Summary ❑ Fetal Monitor Strips ❑ Radiology Images
   ❑ Forensic Sexual Assault Record ❑ Billing Records
   ❑ Medical Record ❑ Other (specify): _____

   Select to indicate whether Substance Use Disorder Records should be included: ❑ Yes ❑ No
6. Reason for release: ❑ Attorney ❑ Continuing Care ❑ Insurance ❑ Personal Use ❑ Other _____
7. Send the health information in the following format: ❑ Paper ❑ Electronic (PDF) ❑ Other _____
8. Delivery Method (note that paper, CD/DVD and USB are delivered by US Mail):
   ❑ CD/DVD ❑ USB ❑ Fax Number: _____
   ❑ Other: _____
   ❑ Email Address: _____ (sent via secure email)

By signing this authorization form, I authorize the release of my health information as specified above. My signature also indicates that I understand/acknowledge the following:

- This authorization will expire 60 days from the date signed unless I write a different date or expiration here:_____.
- A photocopy of this authorization will be treated in the same way as the original.
- This authorization can be cancelled/revoked by me at any time in writing to Franciscan Health. A cancellation will not change releases that happened before the cancellation. I may not be able to revoke the authorization in situations where the authorization was given as a condition of obtaining insurance coverage and law provides the insurance company the right to contest an insurance claim made under the insurance policy.

Franciscan HEALTH

Place Patient Label

Form: Rev: 12-01-23
Barcode Revision: 01-23-26

HIPAA RELEASE OF INFORMATION ACUTE

HIPAA Release of Information Acute

RELEASE OF INFORMATION TO THIRD PARTY AUTHORIZATION FORM

- I understand that I can refuse to sign this authorization, and my refusal will not affect my ability to obtain services, treatment, or payment for services except as allowed under HIPAA regulations.
- Franciscan cannot prevent re-disclosure of my information by the person/organization who receives my records under this authorization, and state and federal law may not protect the privacy of that information once it's released. By signing this authorization, I release Franciscan from any and all liability resulting from a re-disclosure by the recipient.
- State and federal law allow Franciscan to charge a fee for any request for records that will require manual effort to compile and transmit. Please contact us if you have questions or would like an estimate of fees in advance.

I acknowledge that I have read, understand, and received a copy of this authorization. I authorize Franciscan Health to release the health information as described above, including any information related to mental health, communicable diseases (including HIV/AIDS,) and genetics.

SIGNATURE:_____ DATE:_____

RELATIONSHIP TO PATIENT, if other than patient: _____

NOTE: Unless a parent of a minor patient, personal representatives must attach proof of authority to this request.

Franciscan HEALTH

Place Patient Label

Form: Rev: 06-04-25
Barcode Revision: 01-23-26

HIPAA RELEASE OF INFORMATION ACUTE