Women's Healthcare of Southern Indiana, LLC
5300 State Road 64, Ste. 103
Georgetown, IN 47122
Phone: (812) 923-6200 **Fax:** (812) 923-6204

David Murphy, DO
Kayla Stinson, APRN
Carrie Emerson, APRN

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____ _____
(Name of Patient) (Date of Birth) (Daytime Phone Number)

_____
(Address) (City) (State) (Zip)

Dates of Treatment or Service: _____

I authorize Women's Healthcare of Southern Indiana to **DISCLOSE** information specified below to:

Name: _____

Address: _____

City/State: _____

Phone: _____

Fax: _____

I authorize Women's Healthcare of Southern Indiana to **OBTAIN** information from:

Name:_____

Address: _____

City/State: _____

Phone: _____

Fax: _____

Information to be Disclosed

_____Delivery Note
_____Discharge Summary (includes
_____History and Physical/Progress Notes
_____Operative Note
_____Pathology
_____Other, explain: _____

_____Entire Record
_____Lab Results (Specified Date or ALL)
_____Office/Progress Notes
_____Consult Note
_____Letter confirming attendance/treatment
_____Radiology/Ultrasound/Mammogram

Purpose or Need For the Disclosure: Physician/Hospital – Continuity of Care Personal Use Legal Disability
Other, Explain: _____

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department at Women's Healthcare of Southern Indiana. I understand the revocation will not apply to information that has already been released to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to provide an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Date: _____ _____
Signature of patient or legal guardian

Witness: _____ Relationship to patient: _____

Processed by: _____ Date Released: _____
(Women's Healthcare Staff Signature)