Indiana Regional Medical Center
Indiana, PA 15701-0788

Consent to Release of Information

Information to be released to:
Name:_____
Address:_____
_____
_____
Phone: _____

Name of Patient:_____
Address:_____
_____
_____
Birthdate:_____
Phone: _____

Information to be MAILED, HAND-CARRIED or FAXED. (Circle one)

INFORMATION TO BE RELEASED

*********SPECIFIC DATES AND DOCUMENTS NEEDED*********

Inpatient Records: _____
_____
Outpatient Records:_____
_____
Emergency Records: _____

Date to be picked up: _____ MR# _____ DI# _____ Completed by: _____
(Initials)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize _____ to release my health information as indicated above including records concerning psychiatric, alcohol and drug abuse, and HIV related information for the purpose of:

_____
(Continuity of care, disability determination, insurance claim, legal matter, etc.).

I agree that a photocopy or facsimile of this authorization will be as valid as the original. This authorization shall be in effect for sixty (60) days unless otherwise stated. I understand that I may withdraw my permission at any time by written request (except for information already disclosed). I understand that except for certain circumstances covered by U.S. and Pennsylvania laws, a person or organization that receives this information because of this authorization may have the legal right to disclose this information to other people/organizations without my knowledge or consent.

_____/_____/_____ _____
Signature of Patient or Patient Representative Date Time Relationship to Patient

Reason patient unable to consent: _____

_____: ID checked & Verified _____
Initials Staff Witness to Signature

Refusing to sign this authorization will not affect your ability to receive services from IRMC unless the services are performed solely for the purpose of disclosure, i.e. pre-employment physical.