Wellstone Regional Hospital
2700 Vissing Park Road, Jeffersonville, IN 47130
812-284-8000 Fax 812-258-2023

Authorization to Use or Disclose Protected Health Information

(Patient/Resident Name) (Date of Birth) (Date)

I hereby freely and voluntarily authorize Wellstone Regional Hospital to...
Release/disclose my protected health information to and/or obtain my protected health information from

(Individual, Facility, or Organization) (Phone Number)

(Address) (Fax Number)

(City, State, Zip Code)

The purpose of this disclosure is for:
___ insurance purposes ___educational placement ___legal reasons ___ medical treatment
___ discharge planning ___continued treatment ___the patient ___ progress updates
___ other (explain) _____

Information to be used or disclosed:
☑ **Level of Care Recommendation**

___ Discharge summary	___ Psychiatric Evaluation	___ Mental Status	___ History & Physical
___ Psychological testing	___Treatment Plan(s)	___ Lab/X-ray results	___ Progress Report
___ Psychosocial assessment	___ Immunization status	___ Physician's Orders	___ Substance Abuse Tx
___ Aftercare Plan	___Other (explain) _____		

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/ or tuberculosis. I understand that such information is confidential and is protected by federal law*. I understand that provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Well- stone Regional Hospital Privacy Officer, except to the extent that action has already been taken in reliance on it. This authorization will expire in 180 days, following discharge, or following signature unless another date or condition is specified. **Other date or condition specified:_____.**

Signatures:

(Patient/Resident-When applicable by law or hospital policy) *(Date)*

(Guardian or Representative) *(Date)* *(Relationship to Patient/Resident)*

(Witness) *(Date)*