You will receive your bill from Healthport. A $1.00 charge per page for pages 1 through 10, fifty cents ($0.50) charge per page for pages 11-50, and twenty-five cents ($0.25) charge per page for pages 51 and up plus S/H postage.

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Internal Medicine of SE Indiana to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

Authorized to Release:	Authorized to Receive:
______________________	______________________
Releasing Information	To Receive Information
______________________	______________________
Address	Address
______________________	______________________
City / State / Zip	City / State / Zip

This authorization permits Internal Medicine of SE Indiana to use or disclose copies of the following individually identifiable health information:

- [ ] Contents of entire medical record including information on drug, alcohol, mental health and infectious disease.
- [ ] Contents but exclude information on drug, alcohol, mental health and infectious diseases.
- [ ] Contents but exclude information from any other doctors, facilities, etc.
- [ ] Other (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

for the purpose of:____

I understand this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. This consent will expire in 60 days.

Indiana Code #760IAC 1-71-2 provides a written request may be made and provided to you in a specified manner for an appropriate fee, therefore, I understand and agree that I am financially responsible for fees charged for the copying of these records. Internal Medicine of SE Indiana uses an outside service to copy records and all requests will be forwarded to them to provide the service.

I understand this facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent and authorized herein.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that Internal Medicine of SE Indiana has acted in reliance upon this authorization.

Internal Medicine of SE Indiana's Privacy Officer at 1088 N State Road 229, Batesville, Indiana 47006 PHONE: 812-933-1858 FAX: 812-933-1968

Patient Information & Authorized Signatures:

______________________________ ____________ ____________________

Print Name of Patient Date of Birth Relationship to Patient

______________________________ ______________________________

Signature of Patient / Legal Guardian Address

______________________________ ______________________________

Print Name of Legal Guardian City / State / Zip

____

Date

For Office Use:
Action Taken: __________________ Date: ___________ Staff Name: ________________