Secure. Reliable. Easy

2002 S. East Street * Indianapolis, IN 46225

T. 317.803.9715

F. 317-454-8573

AUTORIZACIÓN PARA COMPARTIR INFORMACIÓN DE SALUD

Yo (el abajo firmante) autorizo por este medio a GRM a compartir la siguiente información médica.

INFORMACIÓN DEL PACIENTE

Nombre del Paciente:______________________________ Fecha:______________________________

Nombre de Soltera (si es aplicable): ______________________________SSN: ____________________

Fecha de Nacimiento: __________________________ E-mail: ______________________________

Dirección: ______________________________Teléfono: ______________________________

Ciudad, Estado, Código Postal:____

PROVENIENCIA INFORMACIÓN DE LIBERACIÓN

Proveedor de Salud:

____

INFORMACIÓN QUE SE DEBE LIBERAR

Fechas de Citas Solicitadas: ____

Entiendo que la Información Protegida de Salud en mi historial médico puede incluir información relacionada a Enfermedades Comunicables y Peligrosas como el síndrome de inmunodeficiencia adquirida (SIDA) o el virus de la inmunodeficiencia humana (VIH). También puede incluir información sobre los servicios de salud mental y el tratamiento del abuso de alcohol y drogas.

Información a Compartir:

__ Todos los registros

__ Notas de la visita medica

__ Prescripciones

__ Historia y Física

__ Labs

__ Informe (s) de consulta

__ Resumen (es) de la descarga

__ Prueba y radiografías

__ Informe (s) operativo (s)

__ Nota (s) de Terapia

__MRI / Imágenes de rayos X

__ Facturación detallada

__ MRI / radiografía en CD

__ Otros

Limitaciones: No divulgue información en mis registros con respecto a: ______________________________

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I (the undersigned) hereby authorize, GRM to disclose the following identified health information.

PATIENT INFORMATION

Name of Patient: ______________________ Date: ______________________

Maiden Name (if applicable): ______________________ SSN: ______________________

Date of Birth: ______________________ E-mail Address: ______________________

Address: ______________________ Phone Number: ______________________

City, State, Zip Code: ______________________

RELEASE INFORMATION FROM

Care Provider: ______________________

INFORMATION TO BE RELEASED

Dates of Treatment Requested: ______________________

I understand that the Protected Health Information in my medical record may include information relating to Dangerous Communicable Diseases including acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Information to release:

- ☐ All Records
- ☐ Office Visit Notes
- ☐ Prescriptions
- ☐ History & Physical
- ☐ Labs
- ☐ Consultation Report(s)
- ☐ Discharge Summary(s)
- ☐ Test & X-ray Reports
- ☐ Operative Report(s)
- ☐ Therapy Note(s)
- ☐ MRI / X-ray images
- ☐ Itemized Billing
- ☐ MRI / X-ray on CD
- ☐ Other ______________________

Limitations: Do not release information in my records regarding: ______________________

RELEASE INFORMATION TO (if not patient)

Name: ______________________

Address: ______________________ E-mail Address: ______________________

City, State, Zip Code: ______________________ Phone Number: ______________________

Purpose for disclosure: ______________________

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to GRM, attention: ROI Department, 2002 S. East Street, Suite 1, Indianapolis, IN 46225. I understand that this authorization will expire in sixty, (60) days unless otherwise specified. ***Expiration Date* (if not sixty days)** ______________________.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I am responsible for all fees associated with releasing my health information. I understand that I have the right to refuse to sign this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

Signature of Patient: ______________________ Date: ______________________

Relationship to patient, if other than patient: ______________________

Witness: ______________________ Date: ______________________