I ____, hereby authorize
PATIENT'S FULL NAME AND ADDRESS

☐ KING'S DAUGHTERS' HOSPITAL ONE KDH DRIVE MADISON, IN 47250

☐ CAMPUS MOB 630 N. BROADWAY MADISON, IN 47250
☐ KDH - HILLTOP 445 CLIFTY DRIVE MADISON, IN 47250
☐ KDH - SWITZERLAND COUNTY MEDICAL BLDG 727 W HWY 56 VEVAY, IN 47043
☐ KDH - MEDICAL BLDG 206 W. TYSON STREET VERSAILLES, IN 47042
☐ RIVERBOURNE MEDICAL CTR 205 MARWILL DRIVE CARROLLTON, KY 41008
☐ KDH - HANOVER 36 MEDICAL PLAZA HANOVER, IN 47243
☐ KDH - VEVAY CLINIC 213 MAIN STREET VEVAY, IN 47043
☐ KDH - VERSAILLES CLINIC 128 N MAIN STREET VERSAILLES, IN 47042
☐ TRIMBLE COUNTY MEDICAL BLDG. 10235 US HWY 421 MILTON, KY 40045

☐ OTHER PERSON/ORGANIZATION TO RELEASE INFORMATION: ________________________

to release information contained in my patient medical record **INCLUDING** alcohol and drug abuse records protected under the regulations of 42 Code of Federal Regulations, Part 2, if any, psychiatric psychological service records, if any, social work records, if any, including communications made by me to a social worker psychiatrist/psychologist, and any information regarding communicable diseases and serious communicable diseases and infections as defined by Indiana Department of Public Health rule which can include venereal disease, tuberculosis, **HIV, AIDS OR ARC**, if any, to individuals or organizations listed below under the conditions listed below:

1. PERSON TO WHOM DISCLOSURE IS TO BE MADE: ________________________

   ________________________ FAX NUMBER: ________________________
   ADDRESS (if necessary)

2. DO NOT DISCLOSE THE FOLLOWING (CHECK ALL THAT APPLY):
   ☐ ALCOHOL AND/OR DRUG ABUSE INFORMATION ☐ HIV, AIDS OR ARC INFORMATION ☐ PSYCHIATRIC INFORMATION

3. ________________________
   SPECIFIC AND MEANINGFUL DESCRIPTION OF THE INFORMATION TO BE DISCLOSED - INCLUDE DATES

4. THE PURPOSE AND NEED FOR SUCH A DISCLOSURE:
   ☐ CONTINUATION OF TREATMENT/FOLLOW-UP ☐ BILLING INFORMATION/INSURANCE
   ☐ PER THE REQUEST OF THE INDIVIDUAL
   ☐ OTHER ________________________

5. THIS AUTHORIZATION SHALL BE VALID FOR SIX (6) MONTHS FOLLOWING SIGNATURE.

I understand that I can revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to King's Daughters' Hospital and Health Services. I understand that the revocation will not apply (a) to information that has already been released in response to this Authorization; or (b) if this Authorization was given as a condition of obtaining insurance coverage, when a law provides that the insurance company has the right to contest a claim under the insurance policy. Treatment, payment or eligibility for benefits will not be conditioned upon signing of this authorization.

I understand that my health information that is disclosed under this Authorization may be subject to redisclosure by the recipient and the privacy of my health information will no longer be protected by law.

SIGNATURE(S): ________________________ ________________
PATIENT DATE

________________ ________________ ________________
DRIVER'S LICENSE NUMBER DATE OF BIRTH LAST FOUR DIGITS OF SSN

________________________ ________________
PARENT/GUARDIAN/LEGAL REPRESENTATIVE DATE

____
DRIVER'S LICENSE NUMBER

LEGAL REPRESENTATIVE PAPERWORK: (ATTACH A COPY)
☐ PROOF OF GUARDIANSHIP ☐ DURABLE POWER OF ATTORNEY FOR HEALTHCARE
☐ LETTERS OF AUTHORITY

________________________ ________________
WITNESS SIGNATURE DATE

NO STRAY MARKS BELOW THIS LINE

NS1001

P.O. Box 447 Madison, IN 47250

PATIENT AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

Patient Identification (sticker or)

Name ________________

DOB ________________ Age ____

Date ________________

NS1001 04/09