Instructions for Norton Healthcare
Authorization to Disclose Protected Health Information

Important: Please read all instructions and information before completing and signing the attached form.

An incomplete form may cause delays and/or rejection of the request for documentation.
Please follow the directions carefully.

If you have any questions about the release of your protected health information or this form, please call the Use and Disclosure office at the contact number below for the facility where you or the person you legally represent were treated.

Norton Clark Hospital: 812-283-2275
Norton Scott Hospital: 812-752-8529
Norton King's Daughters' Hospital: 812-801-0520

Requests may also be completed online at https://medicalrecordrequest.nortonhealthcare.org/

The following are instructions for each section. Please type or print as clearly and completely as possible.

1. Include the patient's full and complete name and Social Security number
2. Include any maiden name or other previously used name(s) and complete date of birth (Month/Date/Year)
3. Place an 'X' next to the information requested (Either a Medical Record or Psychiatric Record or both.)
4. Place an 'X' next to the documentation requested if only portion of the record is needed
5. Place an 'X' next to the facility where the patient was treated and identify the specific location if known
6. Identify the date of service or date ranges requested
    a. Example: (Month/Year) 2/09 or (Month/Day-Month/Day/Year) 2-10 – 2-15-09
7. Identify the format in which records should be released

All mailed records will be processed through the United States Postal Service First Class Mail

8. Include the name, street address, city, state, zip code and phone number of the person who the record is to be released
9. Place an 'X' next to the reason for releasing the health information.
10. The patient must sign and date the authorization form.
    a. If a legally authorized representative of the patient is requesting records, please sign, date and indicate specific relationship to the patient. Additional documents maybe requested to indicate the legal rights of the representative to sign for the patient.
    b. Please review the **'Legally Authorized Representative'** questionnaire to see if this applies.

NOTE: If the patient is deceased, one of the following documents maybe requested
a. copy of the death certificate, if available
b. copy of executor paperwork, if applicable

Please return this authorization to: To the **mailing address** of the facility you selected on **section 5** of the authorization.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

1. **Full Name of Patient**: _____ **Social Security#** _____

2. **Maiden Name/Alias:** _____ **Patient's Birth Date:** _____

3. **INFORMATION REQUESTED (X):** ( ) Medical Record ( ) Psychiatric Records ( ) Itemized Bills
   ******If only a portion of the Medical record or Psychiatric record is required please specify *******

4. ( ) Discharge Summary ( ) Emergency Room ( ) Laboratory Results
   ( ) History & Physical ( ) X-Ray Report ( ) Immunization Records
   ( ) Orders ( ) Operative Reports ( ) Progress Notes
   ( ) HIV Test/Status ( ) Nurses Notes
   ( ) Other (Specify)* _____

5. **IDENTIFY THE FACILITY WHERE THE PATIENT WAS TREATED (X):**

( ) **Norton Clark Hospital**
1220 Missouri Avenue
Jeffersonville, IN 47130

( ) **Norton Scott Hospital**
1451 North Gardner Street
Scottsburg, Indiana 47170

( ) **Norton King's Daughters' Hospital**
Downtown Medical Building
First Floor
630 North Broadway
Madison, Indiana 47250

( ) Other, specify Norton location or provider: _____

6. **Identify date of service or date ranges requested including month and year: _____**

7. **Receive records via (Circle one):** MyNortonChart CD via mail Paper records via Mail

The above record is to be released/mailed to the following individual:

8. Name & Title: _____

Street Address: _____

City/State/Zip: _____ Phone Number:_____

9. **THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):**
   ( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes
   ( ) Personal Interest ( ) Other (Specify)_____

The authorization must be signed and dated and may be revoked by notifying Hospital's Health Information Department in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date beside my signature.

Kentucky Law directs health care providers to furnish to a patient, at the patient's request, one free copy of the patient's Medical Record.
I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

If Norton Healthcare is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under this authorization.

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10. **Signature** _____ **Date**_____
Patient, Parent or Legally Authorized Representative

Relationship to the Patient: _____ Phone Number_____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentially is protected by federal and/or state law. Federal and state regulations prohibits you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

NORTON HEALTHCARE

NORTON Children's Medical Group
Affiliated with UL SCHOOL OF MEDICINE

Legally Authorized Representative Questionnaire

Note: To be completed only if requesting the records of a minor or another adult for whom you are the legal representative.

Request for Copies of Medical Record of Minor Patient:

Authorization for the release of medical records may be provided by the custodial parent or legal guardian of the minor patient. Please check the box that designates your authority to sign for the release of the requested medical records:

- ☐ I share joint legal custody of the child for which I am requesting records. Must provide custody papers.
- ☐ I have sole custody of the child for which I am requesting records.
- ☐ I am the Legal Guardian for the child to which I am requesting records. The Legal Guardian must present an order of appointment, signed by a judge, granting him/her guardianship of the minor
- ☐ Married, custody not applicable.

Request for Copies of Medical Record of Adult Patient:

If you are requesting the medical record of an adult patient, other than yourself one of the following relationships must apply. Please check the box designating your rights to authorize release of the requested medical records.

- ☐ Power of Attorney (POA): Must complete and sign the medical record request form and provide a copy of the POA document.
- ☐ Legal Guardian: Must complete and sign the medical record request form and present an order of appointment, signed by a judge granting him/her guardianship of the patient
- ☐ Executor/Administrator of the adult deceased patient's estate. Must complete and sign the medical record request form and provide a copy of the qualification or order of appointment, signed by a judge as the executor or administrator over the estate.
- ☐ Personal Representative – a copy of the death certificate maybe requested

_____ _____

Signature of Parent or Legal Representative Date

_____ _____

Name of Parent or Legal Representative (please print) Phone Number