HP Enterprise Services
950 North Meridian Street
Suite 1150
Indianapolis, IN 46204
www.hp.com

TO: **IFSSA/OMPP/IHCP/Indiana Medicaid**

HP Enterprise Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Person whose records are to be released:

_____
Patient Name d.o.b. SSN

_____
Address

_____
City State Zip Code

I HEREBY AUTHORIZE AND CONSENT TO A DISCLOSURE OF THE FOLLOWING INFORMATION FROM THE ABOVE PATIENT'S HEALTH RECORD:

__**XX**___ **All records (See description below)**

Date(s) of Treatment requested: (can specify "All dates"): _____

Purpose for Release of Health Information: **lien resolution/litigation**

Records are to be released to:_____

_____

_____

I understand that this Authorization may be revoked by me in writing at any time, except to the extent that the covered entity has taken action in reliance thereon.

I understand that this Authorization for release of protected health information includes release of records relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), records of treatment for physical and/or emotional illnesses, records of treatment for alcohol or drug abuse, and records pertaining to communicable diseases and genetic testing. 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. By signing this Authorization, I acknowledge that I have read and understand this Authorization and further, I authorize the use or disclosure of my protected health information in accordance with the terms of this Authorization.

This Authorization expires: **Upon termination of litigation and lien resolution.**

Date: _____ _____
Authorized Signature of patient, guardian, emancipated minor, or personal representative

Relationship to patient or title: _____