PORTER STARKE SERVICES
Health • Balance • Hope

Once completed, submit this authorization form by:

- **Mail to:** Porter-Starke Services, 601 Wall St, Valparaiso, IN 46383, ***or***
  Marram Health Center, 3229 Broadway, Ste 115, Gary, IN 46409, ***or***
- **Fax to:** Porter-Starke Services/Marram Health Center: (219) 462-3975, ***or***
- **Email** using a secure platform to:
  Porter-Starke Services: HIM@porterstarke.org ***or***
  Marram Health Center: MarramHIM@marramhealth.org

Marram Health Center

Consent and Authorization to Release Confidential Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City/State/Zip: _____

Phone: _____ May we leave a message? *Check one:* ❑ Yes ❑ No

I authorize the release of my information between parties as indicated below:

Porter-Starke Services (includes Marram Health Center)
Phone: (219) 531-3500 • Fax: (219) 462-3975

❑ Yes, share my information. **❑ No, do not share my information.**

Information to Be Shared:

❑ **General information needed for Treatment, Payment, and Operations (TPO) only**.
You have the right to request restrictions on disclosures for TPO under 42 CFR § 2.26, and Porter-Starke Services (dba Marram Health Center) will make reasonable efforts to accommodate these requests as described below.

Restrictions are requested for the sharing of TPO with these organizations (please list any health plans, third-party payers, or healthcare providers with whom TPO is requested not to be shared): _____
_____

For the Following Purpose(s):

❑ **For Treatment, Payment, and Health Care Operations.**
NOTE: Ongoing treatment may not be available if you do not consent to the use and disclosure of your information for TPO purposes.

I fully understand that my medical record contains confidential physical, mental health, substance use, communicable disease, genetic testing, reproductive health, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that records not protected by Federal confidentiality rules (42CFR Part 2) may be subject to re-disclosure by the recipient and may no longer be protected by 42CFR Part 2, Federal, or State law. I understand that my consent to the use and disclosure of my information for Treatment, Payment, and health care Operations (TPO) is required to receive ongoing treatment from Porter-Starke Services / Porter-Starke Services dba Marram Health Center. While I may request restrictions on the use or disclosure of my information for TPO, I understand that the program may not be able to honor such requests and that failure to sign this consent may result in the inability to receive or continue treatment, in accordance with 42 CFR Part 2 and 45 CFR Part 164.

Date, event, or condition this authorization expires: _____. If no date, event, or condition is specified, this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written or oral revocation request to the Health Information Department. I understand that revocation for mandated treatment is not permissible. I understand a copy of this form (including a fax) is considered as valid as the original.

My signature below means I understand and accept the terms of this form:

Patient Signature: _____ Date: _____

Printed Name (if signed above by guardian/authorized party): _____ Relationship to Patient: _____

Request Received by: _____

Patient Name: _____ Medical Record Number: _____