



Medical Record Release Authorization
Fax Completed Form To: 317.817.1240

201 Pennsylvania Parkway, Suite 100
Indianapolis, IN 46280
Main Phone: 317.817.1200
Medical Records Fax: 317.817.1240

Patient Name: _____ Maiden Name: _____
DOB: _____ SS#: _____
Home Phone: _____ Cell/Work Phone: _____
Address: _____ City/State/Zip: _____
Email Address: _____

A) I hereby authorize records FROM:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

B) To be released TO:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

C) For the Purpose of:

_____ Litigation _____ Disability
_____ Insurance _____ Work Comp
_____ Self/Personal Copy _____ Other
_____ Transfer or Continuity of Care

Date Range: _____ To: _____

- Physician Office Notes
Digital Images/X-Rays
Operative/Procedure Reports
Other
Cardiology/EKG Reports
Lab/Path Reports
Radiology/X-Ray/MRI Reports
Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, 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.

I understand that I have a right to 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 the Medical Records Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

This authorization will expire one (1) year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

(Date)

(Signature of Patient/Parent/Guardian or Authorized Representative)
(Subject To Fees)