10767 Illinois Street, Suite 3000
Carmel, IN 46032
Main Phone: 317.817.1200
Medical Records Fax: 317.817.1240

Medical Record Release Authorization
Fax Completed Form To: 317.817.1240

Patient Name: ______________________________ Maiden Name: ______________________________

DOB: ______________________________

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 ☐ Cardiology/EKG Reports

☐ Digital Images/X-Rays ☐ Lab/Path Reports

☐ Op/Procedure Reports ☐ Radiology/X-Ray/MRI Reports

☐ Other ☐ Minimum Necessary

I understand that authorizing 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/or drug use.
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 after 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)

PLEASE CHOOSE ONE: ☐ **Mail** ☐ **Fax** ☐ **Office Pick Up:** ☐ **Carmel** ☐ **Greenwood** ☐ **Bloomington**