IU Health Physicians

IMPORTANT – PLEASE READ
$20.00 Copy fee (includes pages 1-10) OR
$ 1.00 per page for the first ten (10) pages &
$ 0.50 for pages 11-50 &
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Purpose for which disclosure is to be made: _____

RECORDS TO BE RELEASED FROM: ***(Name, address, phone and fax number of organization)***

_____

_____

RECORDS TO BE RELEASED TO: ***(Name and address of person or organization)***

_____

_____

ELECTRONIC:
If e-mail user, do you prefer an electronic copy? ☐ Yes ☐ No
If **yes**, your e-mail address is: _____

The medical records of:

Patient's Name: _____
Last First Middle/Maiden

Address: _____
Street City State Zip

Date of Birth: _____ Telephone: (____) _____

Please release the following information: *(please check appropriate information)*

☐ Office Visit Notes ☐ Lab Reports ☐ Diagnostic Test Results ☐ X-Ray Reports ☐ Immunization Records
☐ Medical Records from past two years ☐ Medication List ☐ Summary of Health Information
☐ Other *(specify):* _____

I give permission for IU Health Physicians to release my health information as described above and I understand the following:

1. To stop this authorization I must write a letter to IU Health Physicians. The cancellation will not apply to records that have already been sent out in response to this authorization.
2. This authorization will expire 60 days from the date signed unless I specify an earlier date.
3. Information used or disclosed in response to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy laws.
4. IU Health Physicians cannot refuse treatment for not signing this authorization.

Date: _____ Signature: _____

I understand that this release also pertains to medical records concerning hospitalization or treatment, including but not limited to, information regarding treatment for alcohol/substance abuse, human immunodeficiency virus (HIV)/AIDS, sexually transmitted diseases, or for psychiatric treatment or counseling. I have the right to specifically request that the below records NOT be released from my healthcare providers.

Limitations, if any: *(please check appropriate boxes)*

☐ HIV/AIDS ☐ Mental Health/Psychiatric Disorders
☐ Sexually transmitted diseases ☐ Drug, Alcohol Abuse/Treatment Dates Requested: _____

*I understand that if I limit the release of any of the records listed above the request will require special handling by the practice and may take extra time to process which may result in a higher cost.

Date: _____ Signature: _____
Patient or Parent/Guardian/Legal Representative

Witness Name: _____ Witness Signature: _____

If leaving practice: Why have you chosen to leave? _____

Released by: _____ Date: _____

*Fees for Copies: Federal and state laws permit a fee to be charged for the copying of patient records. This facility may contract with a Business Associate to process requests for medical records. You may be required to pre-pay for the records. If prepayment is not required, then your copies will be mailed along with an invoice from the vendor.