Community
Physicians of Indiana

PRACTICE NAME: FISHERS FAMILY CARE
PRACTICE ADDRESS: 13050 PARKSIDE DR #230
OFFICE #:317-621-1500
FAX#: 317-621-1509

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **SS#**_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Telephone:** _____

- I agree to the release of health records and/or information as stated below.
- I understand that I may refuse to sign this form and that not signing this form will not affect my services, treatment or payment for services; unless the services are only to create a record for someone else, such as physical exam or drug testing for an employer or insurance company; or if the services are research-related and your signature is required so that your results can be used for the research.
- I understand that I may see and copy the information described in this form if I ask for it.
- Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2)* or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding **alcohol and/or substance abuse*, communicable disease documentation, human immunodeficiency virus (HIV) or mental health treatment or counseling.**

I authorize _____ **(practice name) to (circle one) release information to /obtain information from:**

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

The purpose or need for the disclosure: ☐ At the request of the individual ☐ Other (Specify): _____

_____

Date(s) of information to be disclosed: (please circle) All Records or list specific dates_____

Information to be disclosed:
☐ Office Notes ☐ X-Ray report ☐ All Records
☐ Labs ☐ Emergency Room ☐ Other _____

_____

I understand this Authorization is voluntary and I have the right to revoke it at any time prior to its expiration date by written notification to _____ (name of releasing entity). This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to redisclosure by any recipient and no longer protected by federal privacy laws.

The expiration Date for this release is 60 days from the signature date.

Information to be released: ☐ verbally ☐ Photocopy ☐ Faxed ☐ Other _____

_____ _____
Patient Signature (or Parent/Guardian/Representative) Date

_____ _____
Printed name of Parent/Guardian/Representative Legal Authority of Representative

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Released by _____ Date _____ **Correspondence**

Copy of Auth. provided to Individual by: _____ Date _____ **Section**

*Drug and alcohol abuse records are protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.