Clear Form

INDIANA INTERNAL MEDICINE CONSULTANTS – INDIANA PRIMARY CARE ASSOCIATES
CENTER FOR RESPIRATORY & SLEEP MEDICINE – INDIANA INFECTIOUS DISEASE CONSULTANTS

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

PATIENT'S INFORMATION: (Please print)

Patient's name (Last, First, MI)	Date of Birth	Social Security #
Patient's Address (Street, Apt#, City, State & Zip Code)		

(PLEASE CHECK THE ONE THAT APPLIES):

☐ **I hereby request that my medical records be released to:**

_____

INDIANA INTERNAL MEDICINE CONSULTANTS
701 E. County Line Road, #101 & #301
Greenwood, IN 46143 317-885-2860 Fax: 317-885-2869

☐ **I hereby authorize Indiana Internal Medicine to release my records to:**

_____
(Physician/Facility)

_____
(Address) (City) (State) (Zip)

Purpose of Release

☐ Personal use ☐ Changing physicians ☐ Insurance ☐ Attorney ☐ Other

Unless limited below, I understand that this release pertains to medical records concerning treatment, including but not limited to information regarding treatment for alcohol/substance abuse, human immunodeficiency virus (HIV), or for psychiatric treatment or counseling.

Limitations: _____

I understand that this authorization is subject to written revocation at any time except to the extent that the action has been taken based upon it. I also understand that this authorization will expire in 60 days from the date signed unless I specify otherwise.

We provide up to two years of medical records at no cost. Please contact our office if you need medical records beyond two years. Medical Records: 317-885-2860, ext. 4978 or email us at MR@iimconline.com

_____
(Patient/Guardian Signature)

SUBMIT

_____ _____
(Relationship to patient, if other than patient) **(Date)**

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIED WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS.

For Office Use Only:

Released by: _____ Date: _____