## 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	se print)		
Patient's name (Last, First, MI)	Date of Bir	th	Social Security #
Patient's Address (Street, Apt#, City, State	e & Zip Code)		
PLEASE CHECK THE ONE THAT AP	PLIES):		
I hereby request that my med	lical records be released	I to:	
INDIANA INTERNAL MEDICIN 701 E. County Line Road, #10			
Greenwood, IN 46143	317-885-2860	Fax: 317-885-286	9
I hereby authorize Indiana In	ternal Medicine to releas	e my records to:	
(Physician/Facility)			
(Address)	(City)	(State)	(Zip)
Purpose of Release			
Personal use Changing ph	ysicians Insuranc	e Attorney	Other
Unless limited below, I understand that to information regarding treatment for altreatment or counseling.			
_imitations:			
understand that this authorization is suaken based upon it. I also understand to therwise.			
We provide up to two years of medical reverse. Medical Records: 317-885-2860		_	need medical records beyond two
(Patient/Guardian Signature)			
(Relationship to patient, if other t	han patient) (D	ate)	
REDISCLOSURE IS PROHIBITED WIT PERTAINS.	HOUT SPECIFIED WRIT	TEN AUTHORIZATION	OF THE PERSON TO WHOM IT
For Office Use Only:			

Released by: \_\_\_\_\_ Date: \_\_\_\_