Indiana Internal Medicine Consultants
701 E. County Line Road; Greenwood, IN 46143
317-885-2860 (o) 317-885-2869 (f)

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

PATIENT'S INFORMATION: (Please print)

Last Name		**First Name**		**DOB**		**Soc Sec Num**	
Street Address		**CITY**		**STATE**		**ZIP**	

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:**

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 at 317-885-2860, ext. 4978 or email us at MR@iimconline.com.

_____
Patient/Guardian Signature

_____ _____
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: _____