



Community Physicians of Indiana

PENDLETON MEDICAL GROUP

7550 S ST RD 67 PENDLETON IN 46064

OFFICE #765-778-8800

FAX# 765-778-8818

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 abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or mental health treatment or counseling.**

I authorize _____ (practice name) to release information to:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I authorize _____ (practice name) 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 one) past year, past 2 years, past 3 years, past 4 years, past 5 years, All Records, Other _____ (list) _____

Information to be disclosed:

- Office Notes X-Ray report All Records
 Labs Emergency Room Other _____

I understand that this authorization is voluntary and that 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 _____

Signature _____ Date _____ Parent/Guardian/Representative Signature _____ Date _____

Witness _____ Date _____ Legal Authority of Representative _____

Released by _____ Date _____ Correspondence Section

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