

IMPORTANT – PLEASE READ  
\$20.00 Copy fee (includes pages 1-10)  
10-50 pages (\$.50 per page)  
51 pages and over (\$.25 per page)

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

RECORDS TO BE RELEASED FROM: Rehabilitation Associates of Indiana  
717 S. Rogers St.  
Bloomington, IN 47403

I hereby request and authorize the above care provider to furnish records for the purpose of \_\_\_\_\_, or at my request to \_\_\_\_\_

**RECORDS TO BE SENT TO:** \_\_\_\_\_

(Provide complete name, address, suite, zip code, fax # if applicable)

**PATIENT INFORMATION:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

**INFORMATION THAT MAY BE RELEASED**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> All Records          | <input type="checkbox"/> Office Visit Notes | <input type="checkbox"/> Prescription         |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Labs               | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Test & X-Ray(s)    | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Operative Report(s)  | <input type="checkbox"/> Therapy Notes      | _____   |

I understand that this also pertains to records regarding Drug and Alcohol Treatment, Mental Health Records, and Communicable Disease Records, including HIV and AIDS.

Limitation: Do not release information in my record regarding: \_\_\_\_\_  
Release only my records for the dates of \_\_\_\_\_ through \_\_\_\_\_

I understand that (1) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT: (2) THAT THE RECIPIENT OF THESE RECORDS MAY FURTHER DISCLOSE INFORMATION BECAUSE OF THIS AUTHORIZATION AND IT MAY THEN NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS: (3) I AM ENTITLED TO ASK FOR A COPY OF THIS DOCUMENT: (4) I MAY REFUSE TO SIGN THIS AUTHORIZATION AND MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT. THERE MAY BE A CHARGE FOR THE RELEASE OF THESE RECORDS PURSUANT TO INDIANA CODE 16-39-9-3 AND CFR 164.524 (HIPAA)

Signature of Patient or Patient's Representative: \_\_\_\_\_

Description of Representatives Authority to Act for Patient: \_\_\_\_\_

Date Signed: \_\_\_\_\_ Expiration Date : 60 days or earlier date of \_\_\_\_\_

Authorizations for Health Records as defined by Indiana Statute may not be effective for longer than 60 days.

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