AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RECORDS TO BE RELEASED FROM: ____

Address: ____

____

Phone: ____

Fax: ____

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: Rehabilitation Associates of Indiana
6330 E. 75th St Suite 110
Indianapolis, IN 46250
P: 317-588-7130 F: 317-588-7150

PATIENT INFORMATION: ____

Address: ____

____

Phone: ______________ DOB ______________ SS# ___________

INFORMATION THAT MAY BE RELEASED

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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: ______________________________