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
717 S. Rogers St.
Bloomington, IN 47403
P: 812-337-0700 F: 812-337-0714

PATIENT INFORMATION: _____

Address: _____

_____

Phone: _____DOB_____SS#_____

INFORMATION THAT MAY BE RELEASED

_____

_____

_____

_____

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: _____