IU Health Physicians

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	Name ______ Date of Birth ______ Address ______ City ______ State ______ Zip ______ Day Phone ______
Clinic/Hospital/Health Care Provider: (Who has the information you want released? Please list the specific Hospital and/or clinic.)	Name ______ Address ______ City ______ State ______ Zip ______ Phone Number ______ Fax Number ______
Receiving Party: (Where do you want the information sent? Who may have the information?)	Name RECORDS DEPOSITION SERVICE, INC. Address PO BOX 5054 City SOUTHFIELD State MI Zip 48086-5054 Phone Number 248-357-3330 Fax Number 248-357-3337 Attention to ______
Information to be Released: (What do you want sent or released? Check the appropriate box.)	☐ Physician Office Medical Records ☐ Hospital Medical Records Date(s) of Service: From ___/___/___ To ___/___/___ ☐ Billing Records ☐ Copies of Films/Images ☐ Any and all records (includes ALL types of records listed below. If you want to include images and billing records, check those boxes.) Only record types checked below: ☐ Discharge summary/note ☐ Radiology reports ☐ Emergency record(s) ☐ History & Physical Exam ☐ Rehab records (PT/OT/ST) ☐ Immunization/allergy record ☐ Operative report ☐ Laboratory reports ☐ Pathology reports ☐ Consultations ☐ Progress Notes ■ Other records (Specify record types(s) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST
Special Authorization Section (Per IC-16-39-2 this special authorization is valid for 180 days.)	State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate): Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No ☐ N/A Dates ______ HIV Testing and Results ☐ Yes ☐ No ☐ N/A Dates ______ Mental Health Records ☐ Yes ☐ No ☐ N/A Dates ______ Psychotherapy Records ☐ Yes ☐ No ☐ N/A Dates ______ Genetic Records ☐ Yes ☐ No ☐ N/A Dates ______
Release Instructions: (How and When do you want the information?)	Release Method/Format requested: (check one) ☐ Paper ☐ Email ______ E-mail address for link Date information is needed ______ NOTE: Please allow 5-10 business days for processing
Purpose of Release: (Why is it needed?)	☐ Continuing care ☐ Transfer of care ☐ Social Security appeal ☐ Insurance application* ☐ Personal use or review* ☐ Social Security Disability Determination* ☐ Insurance payment/claim ☐ Litigation/legal* ■ Other* PRE TRIAL DISCOVERY *Fees may be charged in accordance with IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

- This authorization will expire in 60 days from the date signed unless otherwise specified ______
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this Authorization in order to receive health care treatment.
- IU Health Physicians' records may include records that it received from other organizations. If these records have been used by IU Health Physicians and filed in the record IU Health Physicians maintains about you, these records may be released with your IU Health Physicians records.
- IU Health Physicians cannot prevent the disclosure of your information by the person ororganization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release IU Health Physicians from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form, and you authorize release of your information as described above.

______ ______
Patient/Legal Guardian Signature Date

______
Authority to act on behalf of patient (Attach documentation)

To be completed by Staff:
Initials of person releasing information ______ Date ______
Photo ID/Signature verified ______
Medical Record Number ______
Patient Encounter Number ______

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Medical Record Copy

Correspondence Non-Confidential

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