FAMILY MEDICINE OF SOUTH BEND, P.C.

University Commons Medical Plaza
6301 University Commons, Suite 210, South Bend, IN 46635
Telephone: (574) 234-4016 Fax: (574) 239-4607

Patient Name_____ Date of Birth _____

Address _____

City_____ State_____ Zip_____

Phone (Home)_____ (Work) _____

Information to be used or disclosed:_____

_____

_____

I understand that my health record may include information relating to sexually transmitted disease, acquired or human immunodeficiency syndrome (AIDS/HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. (IC16-39-2-5, 42 code of Federal Regulations, part 2)

_____I wish this information to be disclosed.

This information may be disclosed to/from:

_____ Patient or requester, at the request of the individual _____

_____ Provide name and address:_____

_____

The patient or the patient's representative must read and initial the following statements: **Initials**

1. I understand the records will be available within two (2) weeks unless I am otherwise notified. _____
2. I understand I must be supervised if I am inspecting my records and there may be a fee for the supervision. _____
3. There may be a fee charged for the cost of furnishing a copy or summary of the health record. _____

Unless revoked, this authorization will expire on _____ or 60 days from the date of signing (IC 16-39-1-1). If patient is part of a research project, this authorization may appropriately have "non" or "at the end of research project" as the expiration date.

I understand that:

1. I have the right to revoke this authorization at any time in writing to present to Family Medicine of South Bend, P.C. medical records department. I understand that revocation does not apply to information that has been released in response to this authorization.
2. Once the information is disclosed pursuant to this authorization, the recipient may re-disclose it and the information may not be protected by federal privacy regulations.
3. I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Family Medicine of South Bend, P.C. is authorized to make the disclosure requested.

Signature of Patient or Legal Representative: _____

If signed by legal representative, relationship to patient: _____

Date: _____

Brief description of reason for record transfer: (please check the appropriate reason)

Insurance purposes _____ Moving_____

Physician dissatisfaction _____ Why? _____

Staff dissatisfaction_____ Why? _____