FAMILY MEDICINE OF SOUTH BEND, P.C

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

NO DISCS

Medical Release Authorization Form

Patient Name _____ Date of Birth ____/____/____
(First) (Middle Initial) (Last)

Address _____ City_____ State_____ Zip_____

Home Phone (____) _____-_____ Cell Phone (____) _____-_____ Work Phone (____)_____-_____

1. Facility Authorized to **RELEASE** Information:
   Name: _____
   Address: _____ City: _____ State: _____ Zip: _____
   Phone: Fax:
2. Person or Facility Authorized to **RECEIVE** the information:
   Name: _____
   Address: _____ City: _____ State: _____ Zip: _____
   Phone: Fax:
3. Specific Health information to be disclosed:
   ___Entire Chart ___Office notes ___Labs ___ Xray reports ___Specific Type of Report:
   DATE(S) of service:
4. *Reason* for request ___Complete transfer from **PCP** ___Complete transfer from **OB/GYN** ___Insurance
   ___Attorney / Legal ___ Seeing a specialist /office referral ___Other /Explain

Patient or representative must read and *initial* the following statements: *I understand...*

1. 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.
2. _____ Records will be available within two (2) weeks unless I am otherwise notified
3. _____ ***There may be a fee charged for the cost of furnishing a copy or summary of the health record***, or the supervision in the inspection of my records.
4. _____ 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. Revocation does not apply to information that has been released in response to this authorization.
5. _____ 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.
6. _____ I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

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 "none" or "at the end of research project" as the expiration date.

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

Signature of patient _____ Date_____

Signature of Legal Representative: _____ Relationship to patient _____ Date_____