



# Community Physicians of Indiana

**OLIO ROAD FAMILY CARE  
13121 OLIO ROAD, SUITE 300  
FISHERS, INDIANA 46037**

**OFFICE #(317) 621-1300**

**FAX # (317) 621-1310**

## AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

- I agree to the release of health records and/or information as stated below.
- I understand that I may refuse to sign this form and that not signing this form will not affect my services, treatment or payment for services; unless the services are only to create a record for someone else, such as physical exam or drug testing for an employer or insurance company; or if the services are research-related and your signature is required so that your results can be used for the research.
- I understand that I may see and copy the information described in this form if I ask for it.
- Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding **alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV,) or mental health treatment or counseling.**

I authorize \_\_\_\_\_ **OLIO ROAD FAMILY CARE to release information to:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize \_\_\_\_\_ **OLIO ROAD FAMILY CARE to obtain information from:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The purpose or need for the disclosure:  At the request of the individual  Other (Specify): \_\_\_\_\_

Date(s) of information to be disclosed: (please circle one) past year, past 2 years, past 3 years, past 4 years, past 5 years, All Records, Other \_\_\_\_\_ (list)

### Information to be disclosed:

- Office Notes     X-Ray report     All Records  
 Labs     Emergency Room     Other \_\_\_\_\_

I understand that this authorization is voluntary and that I have the right to revoke it at any time prior to its expiration date by written notification to \_\_\_\_\_ (name of releasing entity). This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to redisclosure by any recipient and no longer protected by federal privacy laws.

**The expiration Date for this release is 60 days from the signature date.**

Information to be released:  Verbally     Photocopy     Faxed     Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian/Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_ Legal Authority of Representative \_\_\_\_\_

Released by \_\_\_\_\_ Date \_\_\_\_\_ Correspondence Section  
Copy of Auth. provided to Individual by: \_\_\_\_\_ Date \_\_\_\_\_