Authorization for Release of Medical Records

Effective December 2016

Patient Information:	Name: ______________________ DOB: __________ Address: ______________________ Phone: __________ City: __________ State: ______ Zip: ______
Clinic/Hospital/ Health Care Provider:	Name: ______________________ Address: ______________________ Phone: __________ City: __________ State: ______ Zip: ______
Information to be released:	❒ Physician office medical records and notes ❒ Pathology reports ❒ Radiology reports ❒ Laboratory reports ❒ Hospital medical records ❒ Copies of films/images ❒ Immunization records ❒ Rehab records (PT, OT, ST) ❒ Discharge summary/notes ❒ Other (please describe) ______________________
Special authorization section (per Ind. Code § 16-39-2, valid for 180 days):	State and federal law protect the following information. If this information applies to you, please check box and include dates where appropriate: ❒ Alcohol, Drug, or Substance Abuse Records ❒ HIV Testing and Results ______________________ ❒ Mental Health Records ______________________ ❒ Psychotherapy Records ______________________ ❒ Genetic Records ______________________ ______________________
Reason:	The reason for this request to release medical information is: ❒ medical care/treatment ❒ insurance ❒ other (specify): ______________________
Send information to:	Name: ______________________ Address: ______________________ City: __________ State: ______ Zip: ______
Allow communication to:	______________________ ______________________ ______________________ ______________________

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. TruCare's records may include records that it received from other organizations. If these records have been used by TruCare, and filed in the record TruCare maintains about you, these records may be released with your TruCare records. TruCare cannot prevent re-disclosure of your information by the person or organization 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 TruCare from any and all liability resulting from a re-disclosure by the recipient.

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

____ _______________

Signature of Patient / Legal Guardian Date

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Authority to act on behalf of patient (attach appropriate documentation)

<u>Office Use Only:</u>

______ Initials of receiving staff ___________ Date rec'd by staff

❒ Photo ID verified
❒ Documentation verified (if applicable)