



## Authorization for Disclosure of Health Information

2920 McIntire Drive, Suite 350 • Bloomington, Indiana 47403 • 812-332-7337 • Fax 812-339-2934

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

I hereby authorize \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

to disclose my protected health information as described below to \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Please release the following information

- |  |   |
|--|---|
| <input type="checkbox"/> Entire Medical Chart  | <input type="checkbox"/> Surgical Reports           |
| <input type="checkbox"/> X-Ray Reports         | <input type="checkbox"/> Hospital Records/Reports   |
| <input type="checkbox"/> Lab Reports           | <input type="checkbox"/> Developmental Disabilities |
| <input type="checkbox"/> Consultations         | <input type="checkbox"/> Prescription Records       |
| <input type="checkbox"/> Allergy Records/Tests | <input type="checkbox"/> Other (specify) _____      |

I understand that the health information disclosed as a result of this authorization may no longer be protected by Federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

I understand I have the right to:

- **Receive a Copy** of this Authorization
- **Refuse to Sign** this Authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke this Authorization**, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

\_\_\_\_\_  
Signature of Patient (or Legal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient if signed by Legal Representative