



# Community Physicians of Indiana

COMMUNITY PHYSICIANS OF NOBLESVILLE  
13050 PARKSIDE DRIVE, SUITE 260 FISHERS, IN 46038  
OFFICE #317-621-9926 FAX#317-621-9676

## 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 \_\_\_\_\_ (practice name) to release information to:

Name: COMMUNITY PHYSICIANS OF NOBLESVILLE

Street Address: 13050 PARKSIDE DRIVE, SUITE 260

City: FISHERS State: IN Zip: 46038

I authorize COMMUNITY PHYSICIANS OF NOBLESVILLE 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 \_\_\_\_\_

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