Integrative Health Specialists of Indiana
Request and Authorization for Release of Medical Records

9333 N Meridian St. STE 202
Indianapolis, IN 46260
317-580-9333 **Phone**
317-818-8933 **Fax**

I (we), the undersign, hereby request and authorize access to the indicated Medical Record for review, examination, and provisions of such copies as may be requested.

Patient Information:

Name_____
Last First Middle Inital

Address_____
Street City State Zip

Birthdate_____ **Phone#**_____

The undersigned hereby authorizes Integrative Health Specialists, to release and/or request the following portions of medical records of the named patient, via fax or xeroxed copies. A facsimile signature will be considered an original for this purpose.

CHECK ONE BELOW

____Entire medical record, including mental health, alcohol or drug abuse and/or HIV/AIDS information.
____Entire medical record, **with the exception of** information regarding mental health records, including alcohol or drug abuse and HIV/AIDS related treatment.
____The following specific portions of the medical record. (i.e. labs only, dates of service, etc.)

Dates of service _____/_____/_____(mm/dd/yyyy) to _____/_____/_____(mm/dd/yyyy)
Start Date End Date

INDIVIDUAL/INSTITUTION

RELEASING INFORMATION

Name_____
Address_____
_____
Phone#_____
Fax#_____

RECEIVING INFORMATION

Name_____
Address_____
_____
Phone#_____
Fax#_____

PURPOSE OR NEED FOR THE INFORMATION_____
(ie: changing changing practices, continuity of care)

It is understood that this request and authorization may be revoked by me (us) at any time in writing except to the extent that action has been taken in reliance thereon. It is also understood that this consent will expire 60 days from the date signed or upon the subsequently specified date, event or condition:

Expiration Date_____

I (we) further agree that the Practice may charge me or any designated recipients the actual cost incurred in preparing the copy of the requested Medical Records.

Signature_____ Date_____
Address_____ Phone#_____
_____

It is understood that the foregoing is confidential information and will be considered as such. Furthermore, Integrative Specialists is hereby release from liability that might arise from release of such information.

_____ _____
Patient Name (Print) Patient Signature/Authorized Guardian

_____
Date

_____ _____
Witness Date