



Community Physicians of Indiana

ANDERSON FAMILY HEALTH SPECIALISTS
1601 MEDICAL ARTS BLVD., SUITE 100
ANDERSON, IN 46011
OFFICE # 765-298-5700 FAX # 765-298-4912
WWW.ANDERSONFAMILYHEALTH.COM

We charge a minimal fee for copying your medical record. Please see a front office assistant to determine the amount due for your records. We will have your records ready within 10 working days after receipt of a completed release.

AUTHORIZATION FOR RELEASE OF INFORMATION

Pt. Name: _____ Pt. SS#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Telephone: _____ or Cell # _____

- 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 Anderson Family Health Specialists to **RELEASE information TO:**

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I authorize Anderson Family Health Specialists 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): _____

Transferring Out (Please Specify the Reason) _____

Establishing care at AFHS, please select which physician you will be seeing:

Dr. David Dr. Kohles Dr. Rhoades Dr. Shapiro Dr. Shaver Dr. Williams

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, Specific dates: _____ (list).

Information to be disclosed (admission / discharge dates.) _____

Office Notes Emergency Room All Records Labs X-Ray Report Other _____

I understand that this authorization is voluntary and that I have that right to revoke it at any time prior to its expiration date by written notification to Anderson Family Health Specialists. The 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 of this release is 60 days from signature date below.

Information to be released: Verbally Photocopy Faxed Mail Other _____

Patient Signature

Date

Parent/Guardian/Representative Signature

Date

Witness

Date

Legal Authority of Representative

Released by

Date

Copy Auth. Provided to Individual by:

Date

Correspondence Section