Indiana Polyclinic
201 Pennsylvania Pkwy
Suite 200
Carmel, IN 46280
317.805.5500
317.805.5501

MEDICAL/HEALTH RECORDS RELEASE FORM

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

ALL (7) STEPS MUST BE COMPLETED IN ORDER TO PROCES

1

Patient Name: _____ Date of Birth: _____ /_____ /_____
Last First Middle Initial

Address: _____ Telephone: (_____) _____-_____
Street

_____ _____ _____
City State Zip Code

I request and authorize Indiana Polyclinic, PC, to release or obtain the specific records I have indicated to or from the person or organization listed below. I am aware that this information may include substance abuse and or substance dependence, and or mental health documentation. Medical Records should be requested from the facility where treatment was received.

2

- ☐ Assessment Information
- ☐ Treatment Notes
- ☐ Discharge Summary
- ☐ Psychological Testing
- ☐ Admission H & P
- ☐ Diagnostic Tests
- ☐ X-Ray/Imaging Reports
- ☐ Consults
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Financial/Billing Information
- ☐ ALL MEDICAL RECORDS
- ☐ Other (please specify)

3 **For Dates of Services:** _____ /_____/_____ to _____ /_____/_____ OR ☐ **ALL DATES**

4 **Indiana Polyclinic should:** ☐ **Release** Records **TO** OR ☐ **Obtain** Records **FROM**

☐ Person/Organization Listed below OR ☐ SELF/Patient

5

Organization: _____ **or** Individual: _____

Address: _____ Telephone: (_____) _____-_____
Street

_____ _____ _____ Fax: (_____) _____-_____
City State Zip Code

6 **Purpose of Release:** ☐ Treatment / Continued Care ☐ Verbal Communication ☐ Other:

We will process your request as quickly as possible; however, **PLEASE ALLOW UP TO 30 DAYS**
Charges will apply according to Indiana state statute. Records greater than 50 pages can not be faxed.
A $10.00 rush fee will be applied if records are requested to be sent within 2 business days.

By my signature below, I understand that this Authorization may be revoked at any time by sending a written notification to Indiana Polyclinic at the address listed above. If not previously revoked, this consent shall terminate in sixty (60) days. I understand that I am not required to sign this Authorization. IPC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I provide this Authorization. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and is no longer protected by federal privacy regulations. A copy of this Authorization shall be as valid as the original. I have the right to receive a signed copy of this Authorization. Indiana Polyclinic reserves the right to charge for the reproduction of Medical Records in accordance with state law code 760 IAC 1-71-3. Unless listed above, 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 **treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.**

7

_____ _____ /_____ /_____
Patient or Guardian Signature Date