1655 N Gladstone Ave. Suite A
Columbus, In 47201
Main Office 812-376-3100 Toll free 800-319-2348 Main Fax 812-372-1431
Records fax 812-376-4718

Authorization for Release of Medical Information

Name: ____**Date of Birth:** _______________________________________
Last Name First Name Middle Initial

Address: ____
Street Address City State Zip Code

Phone #___________________________ **S.S. #**____

The undersigned hereby authorizes Neurology and Sleep Sciences
_____ Release records to _____ Obtain records from

Name____

Address____
Mailing Address City State Zip Code

Fax: _______________________________________ **Phone:** ____

Information Needed ____

The purpose and need for such a disclosure:
____Continuation of Treatment/follow up ____Legal Purposes ____Billing information/Insurance ____Other

Please initial and sign below

- ❑ **I understand that I may REVOKE this release at anytime, in writing, but the request shall remain valid until revoked or upon the expiration of ninety (90) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon.**
- ❑ **I understand that this release may include medical records of treatment for physical and /or emotional illness, including treatment of information of alcohol or drug abuse. I also understand that HIV, AIDS, or AIDS-related information may also be released.**
- ❑ **I understand that my health information that is disclosed under this Authorization may be subject to redisclosure by the recipient and the privacy of my health information will no longer be protected by law.**
- ❑ **I understand I may be charged for records (Copy fee for patient request: [IN. code 16-39-27])**
  $20.00 retrieval fee (includes 1-10 pages)
  $.50 per page for pages 11 – 50
  $.25 per page for pages 51 +
  $10.00 for expedited requests [IN. code 16-39-9-3]
- ❑ **I understand that all forms and records requests require 7 to 10 business days to complete and a signature must accompany all such request before processing. I also understand by law all request can take up to 30 days.**

Upon completion I would like the information.

________**faxed to # provided above** _________ **pick- up** __________**mailed to above address**

____ ____
Signature (as designated by law) **Date of Signature**

____ ____
Relationship (if other than patient) **Witness**