Authorization for Release of Health Information

Patient Name ____ Date of Birth ______________

The person named above (or authorized representative) must indicate when this authorization expires:

- ☐ When the information is received
- ☐ In one year
- ☐ On date: ______________________

The person named above is or has been a patient of:

Provider/Facility: ____

Address: ____

____

Phone: ____

Fax: ____

The person named above (or authorized representative) herby authorizes Indiana Direct Primary Care to:

- ☐ Request health information/records from date(s) _____________ to ______________
- ☐ Request all records regarding assessment, diagnosis, and treatment of patient's condition(s)
- ☐ Other: ____

I also hereby authorize release of information regarding:

	Initials	Date
☐ Alcohol or Drug use/abuse treatment	__________	_____________
☐ Mental health treatment	__________	_____________
☐ HIV status or treatment	__________	_____________

Authorization by Patient or Authorized Representative

Printed Name: ______________________________

Signature: ______________________________

Date: ______________________________

Witness: ______________________________

- ☐ Parent or Guardian of minor child
- ☐ Guardian or Conservator of conserved patient