Authorization To Release Medical Records

Patient Name		Date of Birth
Street Address		
City	**State**	**Zip Code**
Telephone Number	**Email Address**	

• I hereby voluntarily authorize and consent to release of my health records as indicated below.

• This request is made in accordance with Indiana State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Further, in accordance with the Privacy Rule, a covered entity may release protected health information pursuant to a copy of a valid and signed Authorization, including a copy that is received by facsimile or electronically transmitted.

• 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 medical cptreatment, including but not limited to information regarding **treatment and related services for alcohol and/or substance, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.**

Name of Medical Facility Releasing Medical Records

Address of Facility Releasing Medical Records

Telephone Number of Facility Releasing Medical Records

Specific Information To Be Released

- ☐ Entire medical record
- ☐ Medical record from (insert date) _____ to (insert date) _____.
- ☐ Other_____
  _____

Purpose or Need For Release of Medical Record

- ☐ At the request of the individual
- ☐ Other_____

Send Requested Records To

Kauffman Eye Care
1821 North Shadeland
Indianapolis, IN 46219
Fax 317-870-1583

If Not The Patient, Name of Person Signing Form	Authority to Sign on Patient's Behalf

_____ _____

Signature of Patient/Representative Authorized By Law **Date**