INDIANA JOINT REPLACEMENT INSTITUTE

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Indianapolis, IN 46203
(317) 620-0232
Fax: (260) 208-9561

AUTHORIZATION TO RELEASE HEALTH INFORMATION

RECORDS TO BE RELEASED TO:

Name: _____

Address: _____
Street City State Zip Code

Phone: _____ FAX: _____

RELEASE THE MEDICAL RECORDS OF:

Patient: _____

Address: _____
Street City State Zip Code

Date of Birth: _____ Phone: _____

Please release the following information: *(please check appropriate information)*

☐ Office Visit Notes ☐ Lab Reports ☐ Diagnostic Test Results ☐ X-Ray Reports ☐ Operative Reports

☐ Medical Records from past two years ☐ Medication List ☐ Summary of Health Information

Other (specify): _____ Dates of Records: _____

Purpose for which disclosure is to be made: _____

I give permission to Indiana Joint Replacement Institute ("IJRI") to release my health information as described above and I understand the following:

1. To revoke this authorization, I must request a revocation in writing. The cancelation will not apply to records that have already been sent out in response to this authorization.
2. This authorization will expire in 60 days from the date signed unless I specify an earlier date.
3. Information used or disclosed in response to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy laws.
4. Treatment cannot be refused for not signing this authorization.

Date: _____ Signature: _____

I understand that this release also pertains to medical records concerning hospitalization or treatment, including but not limited to, information regarding treatment for alcohol/substance abuse, human immunodeficiency virus (HIV)/AIDS, sexually transmitted diseases, or for psychiatric treatment or counseling. I have the right to specifically request the that the below records NOT be released from my healthcare providers.

Limitations, if any: *(please check appropriate boxes)*

☐ HIV/AIDS ☐ Mental Health/Psychiatric Disorders ☐ Sexually transmitted diseases

☐ Drug, Alcohol Abuse/Treatment Dates Requested: _____

Date: _____ Signature: _____
Patient or Parent/Guardian/Legal Representative

Witness Name: _____ Witness Signature: _____

*Fees for Copies: Federal and state laws permit a fee to be charged for the copying of patient records. I understand that I am responsible for paying the copy fees, if applicable. I have a right to an estimate of the fees prior to receiving a copy of the medical records.

Received by: _____ Date: _____