HEALTH RECORDS REQUEST/RELEASE AUTHORIZATION

PLEASE FILL OUT THE FORM COMPLETELY

Patient Name (Please Print) _____ Date: _____
Last Name/ First Name/ M.I./ Maiden (if applicable)

Social Security # _____-_____-_____ Birth Date _____ /_____ / _____
Month Day Year

Current Address _____ City _____ State _____ Zip _____

Phone # (_____) _____

I HEREBY AUTHORIZE UNITY HEALTHCARE TO RELEASE MY HEALTH RECORD(S) TO:	**I HEREBY AUTHORIZE**
Provider's Name: _____	_____
Provider's Address: _____	**[Insert Name of Provider]**
_____	**TO RELEASE MY HEALTH RECORD(S) TO:**
☐ Fax Number: _____	Provider's Name: Lafayette Gastroenterology A Division of Unity Healthcare
If you are requesting the records be released to you personally, indicate how you would like them released:	Provider's Address: 5 Executive Drive, Suite B1 Lafayette, IN 47905
☐ Electronic (if applicable)	
☐ Paper Copy	

Purpose for release: _____

The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases, pregnancy, and HIV/AIDS.

PLEASE CHECK APPLICABLE REQUEST:

_____ **ALL** Health Record(s) (may include mental health, drug or alcohol use/abuse, communicable diseases, pregnancy and HIV/AIDS)
_____ Only pregnancy related information from _____ to _____
_____ Only gynecological information from _____to _____
_____ Only X-rays/lab results from _____ to _____
_____ Only prescriptions from _____ to _____
_____ Other - Please specify information to be released: _____

_____

This Authorization shall expire ninety (90) days from the date of its execution or upon my express revocation, whichever occurs earlier. I understand that I may revoke this Authorization at anytime by submitting a written request to: _____. Such revocation shall become effective immediately, except to the extent that Unity Healthcare, LLC has taken actions in reliance on it.

I understand that Unity Healthcare, LLC will not condition treatment, payment, enrollment or eligibility for benefits on me signing this Authorization.

I further understand that my protected health information that is used or disclosed under this Authorization may be subject to redisclosure and no longer protected by the law.

_____ _____ _____ _____
Patient Signature Date Parent/Guardian Signature Date

Record released by: _____ Date: _____