HEALTH RECORDS REQUEST/RELEASE AUTHORIZATION

PLEASE FILL OUT THE FORM COMPLETELY

Patient Name_____Todays Date_____

Date of Birth _____ Phone # (_____) _____-_____

Current Address_____

City_____State_____Zip_____

I HEREBY AUTHORIZE UNITY HEALTHCARE TO RELEASE MY HEALTH RECORD(S) TO:	**I HEREBY AUTHORIZE:**
Providers Name_____ Provider Ph# _____ Providers Fax #_____ If you are requesting the records to be released to you personally, indicate how you would like them released: ☐ Electronic (if applicable) ☐ Paper Copy	Provider Name_____ Provider Ph or Fax#_____ **TO RELEASE MY HEALTH RECORD(S) TO:** **Preferred Pediatrics of Lafayette** *A Division of Unity Healthcare* 3774 Bayley Dr Ste B Lafayette, IN 47905 Phone: 765-807-8180 Fax: 765-807-8181

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

PROVIDER PLEASE CHECK APPLICABLE REQUEST:

_____ **ALL** Health Record(s) (may include mental health, drug or alcohol use/abuse, communicable diseases, pregnancy and HIV/AIDS)
_____ Health information for the dates(s): _____
_____ Immunization record
_____ Growth charts
_____ Other_____

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 the Authorization may be subject to re-disclosure and no longer protected by the law.

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Patient/Parent/Guardian Signature Date