HEALTH RECORDS REQUEST/RELEASE AUTHORIZATION FORM

Patient Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Phone _____

Clinic/Practice/Health Care Provider:

(Who has the information you want released? Please list the specific practice and/or clinic.)

Name _____

Address _____

City _____ State _____ Zip _____

Receiving Party:

Choose One:

☐ Me ☐ Other

(Where do you want the information sent? Who may have the information?)

Name Preferred Pediatrics of Lafayette

Address 3774 Bayley Dr Ste B

City Lafayette State IN Zip 47909

Phone Number (765) 807-8180 Fax Number (765) 807-8181

Information to be Released:

What do you want sent or released? Check the appropriate box.)

☐ All Unity Health Records

(May include mental health, drug or alcohol use/abuse, communicable diseases, pregnancy, and HIV/AIDS)

Date(s) of Service: From _____ To _____

☐ Discharge Summary/Note	☐ Radiology Reports	☐ Office Visit Records
☐ History & Physical Exam	☐ Rehab Records (PT/OT)	☐ Immunization Records
☐ Operative Report	☐ Laboratory Reports	☐ Pathology Reports
☐ Consultations	☐ Copies of Films/Images	☐ Itemized Billing Record

☐ Other _____

Special Authorization Section

(Per IC-16-39-2 this special authorization is valid for 180 days.)

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No
HIV Testing and Results	☐ Yes	☐ No
Mental Health Records	☐ Yes	☐ No
Psychotherapy Records	☐ Yes	☐ No
Genetic Records	☐ Yes	☐ No

Release Instructions:

(How and when do you want the information?)

Release Method/Format requested: (check one)

☐ Electronic Access – E-mail address _____

☐ Paper ☐ CD/DVD ☐ Fax ☐ USB Flash Drive

Date information is needed ASAP - Please (Our goal is to process all requests within 5 business days upon receipt)

By initialing here, I understand that unencrypted e-mail or media (e.g. CD, DVD, USB Flash Drive, etc.) is not considered a confidential means of communication. I have been offered a secure method to receive my records and I have chosen to receive without the protection of encryption. I agree to waive any rights that I may have against Unity Healthcare, any affiliated organization, or physician, or the suppliers, for any compromised information due to the technical failures and/or unintended breach of confidentiality.

Purpose of Release:

(Why is it needed?)

☐ Personal Use ☐ Insurance ☐ Social Security/Disability ☐ FMLA

☐ Continuing Care ☐ Transfer of Care ☐ Litigation/Legal ☐ Other _____

*Fees may be charged in accordance within Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

- This authorization will expire in 90 days from the date signed unless otherwise specified _____
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to theabove-named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this Authorization in order to receive health care treatment.
- UHC's records may include records that it received from other organizations. If these records have been used by UHC, and filed in the record UHC maintains about you, theserecords may be released with your UHC records.
- UHC cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be coveredby state and federal privacy protections after it is released. By signing this authorization, you release UHC from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form, and you authorizerelease of your information as described above.

_____ _____

Patient/Legal Guardian Signature Date

_____

Authority to act on behalf of patient (attach documentation)

TO BE COMPLETED BY OFFICE STAFF:

Date: _____

Initials of person releasing information _____

REV 3/2021