

Brillhart OB/GYN

Community Physicians of Indiana

James Brillhart, MD

PLEASE NOTE THAT THERE MAY BE A FEE FOR RECORD(S) REQUEST. PLEASE CONTACT OUR OFFICE DIRECTLY @ (317) 621-2400, CHOOSE OPTION 1, SHOULD YOU HAVE QUESTIONS REGARDING THE FEE. STATE LAW STATES THAT THE PROVIDER MAY CHARGE A \$15.00 RETREIVAL FEE (INCLUDES THE FIRST 10 PAGES) AND \$0.25 FOR EVERY PAGE AFTER, PLUS POSTAGE.

Name: _____ SS# _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Telephone: _____

- I agree to the release of health records and/or information as stated below.
- I understand that I may refuse to sign this form and that not signing this form will not affect my services, treatment or payment for services; unless the services are only to create a record for someone else, such as physical exam or drug testing for an employer or insurance company; or if the services are research-related and your signature is required so that your results can be used for the research.
- I understand that I may see and copy the information described in this form, if I ask for it.
- 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 hospitalization or treatment, including but not limited to, information regarding **alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or mental health treatment or counseling.**

I authorize Brillhart OB/GYN to release information to: _____

I authorize Brillhart OB/GYN to obtain information from: _____

The purpose or need for this disclosure: At the request of the individual Other (Specify): _____

Date(s) of information to be disclosed: (please circle one) past year, past 2 years, past 3 years, past 4 years, past 5 years, ALL records, Other (list) _____

Information to be disclosed:

- Office Notes X-Ray report All Records
 Labs Emergency Room Other _____

I understand that this authorization is voluntary and that I have the right to revoke it at any time prior to its expiration date by written notification to Brillhart/OBGYN. This revocation will not have any effect on the information released pursuant to this authorization before the revocation. I understand that the information released may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

The expiration date for this release is 60 days from the signature date.

Information to be released: Verbally Photocopy Faxed Other _____

Signature _____ Date _____

Parent/Guardian/Representative Signature _____ Date _____

Witness _____ Date _____

Legal Authority of Representative _____

Released by _____ Date _____ Correspondence
Copy of Auth. Provided to Individual by: _____ Date _____ Section