WITHAM HEALTH SERVICES

Small Hospital. Big Medicine.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I authorize former Dr._____ Address:_____

Phone number:_____ Fax:_____ City, State, Zip:_____

To release information from the health records of:

Patient Name:_____ DOB:_____ SSN:_____

Patient Name:_____ DOB:_____ SSN:_____

Patient Name:_____ DOB:_____ SSN:_____

Information to be released: ☐ Copy of complete medical records

☐ Other (specify):_____

Information to be released to:

☐ Jane Buroker, MD ☐ Caitlin Canal, MD ☐ Janice Kunkel, MD ☐ Candy Riggins, MD

☐ Alyssa Swick, MD ☐ Laura Thieme, MD ☐ Julie Friend, MD

Information to be sent to:

☐ 2705 N. Lebanon St., Suite 415, Lebanon, IN 46052
Phone: 765-485-8900 Fax: 765-485-8909

☐ 6085 Heartland Dr., Suite 208, Zionsville, IN 46077
Phone: 317-768-2222 Fax: 317-768-2229

Purpose of disclosure:_____

I authorize the release of any and all medical records and reports concerning my medical history, physical condition diagnosis, treatment and/or prognosis, including x-rays, images and other diagnostic reports, as well as any information contained in my medical records or reports that related to treatment and/or history of psychiatric or mental health problems, drug or alcohol abuse problems, dangerous communicable diseases, including aids or tests for infections with HIV and any other information related to my treatment. This release shall apply to any and all data listed above unless otherwise indicated by the patient as follows:

DO NOT RELEASE INFORMATION CONTAINED IN MY RECORDS REGARDING:

_____

RELEASE ONLY MY RECORDS FOR THE DATES OF _____ THROUGH _____.

I understand this consent can be revoked in writing at any time to Witham Health Services, except to the extent that disclosure made in good faith has already occurred in reliance to this consent. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Witham Health Services will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I understand I have the right to: 1) inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), 2) Refuse to sign this authorization, 3) Receive a signed copy of this authorization. This authorization is valid for sixty (60) days after the day this request is made and/or for the length of the pending claim, unless otherwise stated as follows:

_____

Parent/Legal Guardian Signature:_____ Date/Time:_____