Pediatric Physician Services
2705 North Lebanon Street, Suite 415, Lebanon, IN 46052
Phone: (765) 485-8900 Fax: (765) 485-8909
6085 Heartland Drive, Suite 208, Zionsville, IN 46077
Phone: (317)768-2222 Fax: (317) 768-2229

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize ☐ Dr. Jane Buroker ☐ Dr. Caitlin Canal ☐ Dr. Janice Kunkel ☐ Dr. Candy Riggins
☐ Dr. Alyssa Swick ☐ Dr. Laura Thieme ☐ Dr. Julie Friend

to release information from the following medical records of:

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Address: _____ City:_____ Zip:_____

Description of information to be released:
☐ All Medical records
☐ Medical records for date(s) of service(s) From:_____ to _____
☐ Other: _____

Information to be released to: _____

_____

Purpose of the release: ☐ Transfer Medical care ☐ Referral/Consultation
☐ Other: _____

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 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 RECORD REGARDING:**

_____

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 of 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 5the day this request is made and/or for the length of the pending claim, unless otherwise stated as follows:_____.

_____ _____ _____
Signature of patient/legal representative Date/Time Signed Authorization expires