

7855 S. EMERSON AVE, STE D

INDIANAPOLIS, IN. 46237

PHONE: (317) 887-9800

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Authorization to Release Protected Health Information

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, or my authorized representative, authorize Dr. Ensley to **RELEASE/REQUEST** (Circle one) the following health information (Check below)

\_\_ Medical records from date \_\_/\_\_/\_\_ \_\_ Gyn records only \_\_ Ob records only

Exemption(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of release: (Check below)

\_\_ Transfer of care \_\_ Coordination of care Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Exchanging Information with Ensley Ob/Gyn:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that this authorization is voluntary, and I may revoke it at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization.
* I understand that signing this authorization is voluntary. My treatment, payment, and insurance status will not be conditioned upon my authorization of this disclosure.

Name Date