Medical Records Release Form

I hereby authorize the office of Noblesville Family Care to release the following information from the health records of:

Print Patient Name _____ Date of Birth _____

Patient Address _____ City, State, Zip _____

Patient Telephone _____ Social Security Number _____

Information to be released to: _____

Name of Physician _____ Physician Telephone _____ Physician Fax _____

Physician Address _____ City, State, Zip _____

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 relates 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 HIC and other information related to treatment.

This release shall apply to any and all information listed above unless otherwise indicated by the patient as follows:

Information to be released:

- ☐ Copy of complete health record(s)
- ☐ History and physical
- ☐ Lab report(s)
- ☐ Bone density report(s)
- ☐ X- Ray report(s)
- ☐ Other _____

Do not release information contained in my record regarding: _____

Release only my records for the dates of _____ through _____

- » *I understand this consent can be revoked in writing at any time to Noblesville Family Care except to the extent that disclosure made in good faith has already occurred in reliance of this consent.*
- » *I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*
- » *Noblesville Family Care will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.*
- » *I understand that 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 extend 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 date this request is made and/or for the length of the pending claim, unless otherwise stated as follows:* _____

Patient's Signature: _____ Date: _____

(Or signature of legal representative if patient is a minor incompetent)