Indiana University Health
Bloomington, Indiana

Health Information Management Services
AUTHORIZATION FOR RELEASE/RECEIPT OF INFORMATION

Important – Please Read: Copy Fee for Patient Records

Labor charges plus first (1-10) pages	$20.00	Certified Medical Record ……....	$20.00
Per page 11-50 …..……$	.50	Copies requested within 2 working days……	$10.00
Each additional page (50+) ……..…..$	.25		

Patient Name _____ Date of Birth _____ MRN _____

Patient Address _____

Previous Name(s) _____ Social Security Number _____

I authorize Indiana University Health to:

☐ release to ☐ receive from
☐ verbally communicate with

_____
(Name of Person or Agency)

_____
(Address)

_____
(City, State & Zip Code)

_____
(Area Code & Telephone Number)

For Health Information Management Services Use Only

The following information:

☐ To View Record Only
☐ Consultation Report
☐ EEG, EKG
☐ Radiology Report
☐ Progress Notes
☐ Operative Report
☐ Discharge Summary
☐ Lab Report
☐ Digital Images
☐ History & Physical
☐ Pathology Report
☐ Emergency Record
☐ Short Stay Record
☐ _____
☐ **Entire Record except** _____

Entire Record includes all of the above plus physician orders, nursing notes and consents.

What dates of service do you need? _____
(Medical Records are retained for ten years at IU Health.)

The purpose of this release is for:

☐ Further Treatment
☐ Insurance
☐ Military
☐ Legal
☐ School
☐ _____

_____ ☐ M ☐ F _____
Patient-Last Name, First Name, Middle Initial — Age

_____ _____ _____
Admission Number — Date — Birth Date

_____
Physician Name

Patient Identification — _____ Medical Record Number

Please check which location:

☐ Indiana University Health Main
Health Information Management
P.O. Box 1149
Bloomington, IN 47402
Phone (812) 353-9475
Fax (812) 353-9298

☐ Behavioral Health
445 S. Landmark Avenue
Bloomington, IN 47403
Phone (812) 353-3450
Toll Free (800) 387-3440
Fax (812) 353-3475

I understand that my health record may include information relating to communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS); or tests for HIV as well as mental health and/or chemical dependency treatment (as defined in I.C. 6-41-2).

IU Health may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing at any time by following the directions in the IU Health Notice of Privacy Practices, except to the extent that IU Health has already acted based on this authorization. I understand this authorization shall expire upon the date indicated below or upon the date of my expressed revocation. A photocopy/fax of this form is as valid as the original. The information disclosed under this authorization may be subject to re-disclosure by the recipient. My signature certifies that I am the person authorized to permit disclosure under this authorization, and I acknowledge that any misrepresentation to obtain protected health information is punishable under penalty of law.

Consent will expire in 60 days unless otherwise noted. Mental Health records expire in 180 days.

Signature _____ Date _____ Expiration Date _____

☐ Patient ☐ Healthcare Representative/Healthcare POA

☐ Parent ☐ Court Appointed Guardian ☐ _____

Signature _____ Date _____
Witness

_____ ☐ M ☐ F _____
Patient-Last Name, First Name, Middle Initial Age

_____ _____ _____
Admission Number Date Birth Date

_____
Physician Name

Patient Identification _____
Medical Record Number