

Authorization For Use or Disclosure of Health Information

Southern Indiana Pediatrics, LLC

350 S. Landmark Avenue • Bloomington, IN 47403 • (812) 335-2434

651 S. Clarizz Boulevard • Bloomington, IN 47401 • (812) 333-2304

5927 W. State Road 46 • Bloomington, IN 47404 • (812) 876-3800

1614 25th Street • Bedford, IN 47421 • (812) 277-0118

Patient's Name

Patient's Birthdate

Patient's Street Address, City, State & Zip Code

The undersigned hereby authorizes Southern Indiana Pediatrics, LLC to release the following portions of the health records of the above named patient:

_____ Entire health record for the period of _____ to _____

_____ The following specific portions of the health record: _____

Release this information to:

Name of person or institution authorized to receive requested information

Street Address, City, State & Zip Code of person or institution

This information is needed for the following purpose:

(State the purpose for the use or disclosure)

I understand that:

- I may REVOKE this release at any time, in writing to Southern Indiana Pediatrics, LLC, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that information has already been released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
- 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 privacy laws or regulations.
- Information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (AIDS). It may also include information about physical and/or emotional illness, including treatment of alcohol or drug abuse.

Signature of Patient or Personal Representative

Phone Number

Date of Signature

Relationship (if other than patient)

Witness

Released by

Date

**Patient/Personal Representative to be provided with a signed copy of Authorization*

Rev. 05/07