NORTHERN INDIANA HAND&WRIST CENTER

NAME: _____ **DATE OF BIRTH:** _____

MEDICAL INFORMATION RELEASED FROM:

Northern Indiana Hand & Wrist Center

***OR*: (Fill out below)**

Name: _____

Address: _____

_____

Phone: _____

MEDICAL INFORMATION RELEASED TO:

Northern Indiana Hand & Wrist Center Self

***OR*: (Fill out below)**

Name: _____

Address: _____

_____

Phone: _____

I authorize the release of the following information:

_____ All my health information maintained by the above-named practice

If applicable, circle "include" or "exclude for each of the following:

Include	Exclude	My health information related to drug abuse and/or alcohol abuse
Include	Exclude	My health information related to HIV/AIDS
Include	Exclude	My health information related to behavioral health

Please read and sign below:

I understand that I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form: (1) to take part in a research study; (2) to receive health care when the purpose is to create health information for a third party

This authorization is valid for a period of one year, and I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. Two ways to revoke this authorization are: (1) fill out a revocation form available from the above-named medical office OR (2) write a letter to the above named office.

I understand that once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I understand that medical record charges are in charged in accordance with current state statute. These charges will be applied EACH time I request my records unless they are being provided directly to my referring physician or to a physician to whom NIHW is referring me. I am responsible for paying these charges, and my records will be released once payment is received. Charges are shown on the back of this release.

_____ _____

Patient Name, Printed Date

_____ _____

Signature of Patient or Representative if A Minor Relationship