Phone (317) 887-2800 *Fax (317) 300-0078*

Authorization for Release of Patient Information

Patient's Name: _____ **Date:** _____

Address: _____

DOB: _____

I hereby authorize the release of information as listed below:

From: _____ **To:** _____

_____ _____

_____ _____

I authorize the release of my health information identifying me including when applicable information on substance abuse, AIDS, or HIV infection and mental health information. I understand that I can revoke this authorization, in writing at any time by sending written notification. I understand that I have the right to inspect or copy health information used or disclosed as allowed by federal law. I understand that information used or disclosed pursuant to this authorization could be subject to disclosure by the recipient. It is my decision to sign this authorization.

Purpose of request: Request of Patient **Other:** _____

Please release the following information:

Complete copy of my records	**Eyeglass information**	**School report**
Copy of last exam	**Insurance information**	**Report to patient doctor**
Summary report/letter	**BMV Application**	**Medication List**
Contact lens information		
Other:		

_____

Signature of patient or responsible party: _____

A parental signature is required for minors (under age 18). When a patient is deceased, physically or mentally impaired the appropriate representative of the patient must sign this authorization.