AUTHORIZATION FOR RELEASE OF INFORMATION

Southpointe Pediatrics 8851 Southpointe Dr. C-1 Indpls, In 46227
317-887-3344 Fax# 317-885-5018

Patient Name: ______________________________

Street Address: ______________________________

City: ____________________ State: ______________ Zip: ________

Date of Birth: ______________ Telephone: ____________________

I hereby authorize and consent to disclose of health records as stated below. Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law(IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or mental health treatment or counseling.

1. Information to be disclosed (dates of service): ______________

- ☐ Office Visit/Progress Notes
- ☐ Laboratory Reports
- ☐ Radiology Reports (x-ray, CT, MRI, etc.)
- ☐ FMLA paperwork
- ☐ Work/School Note
- ☐ Immunization record only
- ☐ Complete Daycare/Sport Form
- ☐ **All Records in chart-may include billing/insurance information**

Other: ______________________________

2. I authorize ____________________ **office# or fax#** ______________

to release information to:

- ☐ Gregory L. Smith, M.D.
- ☐ Steven R. Asdell, M.D.
- ☐ Margaret D. Workman, M.D.
- ☐ Allison M. Koepke, M.D.

Southpointe Pediatrics
8851 Southpointe Drive C-1
Indianapolis, IN 46227

3. The purpose or need for this disclosure(required): ____________________

4. This consent is valid for as long as reasonable necessary to fulfill the purpose for which it is given. This will not exceed 60 days.
5. This consent may be revoked at any time, except to the extent that action has already been taken. To revoke this authorization, I will notify the Privacy Contact in writing
6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
7. I understand that the information used or disclosed may be subject to redsclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.
8. The person sending us records you are requesting may charge a fee. The person requesting the records as signed below is responsible for all associated fees.
9. You have a the right to request a copy of this authorization if requested.
10. **How information will be released:**

☐ **Photocopy**

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Date **Signature of Parent/Guardian/ Patient if at least 18 yrs. of age**

This signature also pertains to records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) or State Law (IC 6-39-2).