



1801 N SENATE BLVD #355 · INDIANAPOLIS, IN 46202

Phone: 317-924-8420

Fax: 317-924-6785

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's

Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

I request and

authorize **NEPHROLOGY & INTERNAL MEDICINE, INC.** to

release and/or request healthcare information of the patient named above to/from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhoea.

Yes No

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I (we) further agree that the Practice may charge me or any designed recipients, the actual cost incurred in preparing the copy(s) of the requested Medical Records.

Patient Signature: _____ **Date Signed:** _____

THIS AUTHORIZATION EXPIRES NINETY DAYS (90) AFTER IT IS SIGNED.