

Excell for Life
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Indianapolis, IN 46260
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**Medical Record
Release
Authorization**

Patient Name _____ Maiden Name _____ SS# _____

Date of Birth _____ Home Phone _____ Cell/Work _____

Address _____ City/State/Zip _____

Email Address: _____

A) I hereby authorize records FROM:

Name _____

Address _____

City/State/Zip _____

Phone# _____ Fax# _____

B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone# _____ FAX# _____

C) For the purpose of:

_____ Continuity of Care/Transfer of Care

_____ Self/Personal Copy _____ Litigation

_____ Insurance _____ Disability

_____ Work Comp _____

Date Range _____ to _____

Physicians Office Notes

Cardiology/EKG Reports

Immunizations

Lab/Path Reports

Operative/Procedure Reports

Radiology/XRay/MRI Reports

Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

(Date) _____ ****Subject to Fees**
(Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

***PLEASE READ Fee Information:** *Excell for Life* contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by the State of Indiana (760 IAC 1-71-3). A \$20.00 handling fee to include the first 10 pages, \$0.50 per page for pages 11-50, \$0.25 per page for pages 51+ and postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.