Authorization to Release Protected Health Information to
FAMILY MEMBERS / CARETAKERS

1) Patient name: ________________________________ D.O.B. _____________ Chart # ____________

2) By my signature below I authorize Indiana Health Group to release my medical records and communicate with the parties listed below in regards to appointments, account information, and treatment.

Name: ____________________________ Relationship: __________ Phone: ______________

Name: ____________________________ Relationship: __________ Phone: ______________

Name: ____________________________ Relationship: __________ Phone: ______________

Name: ____________________________ Relationship: __________ Phone: ______________

By my signature below I understand the following:
This authorization **will be valid for the duration of treatment.**
This authorization may be revoked at any time by sending written notification to Indiana Health Group.
This release prohibits redisclosure except in accordance with 42 C.F.R., 21 et seq., which is a federal regulation governing release and use of patient record information pertaining to treatment for alcohol and drug abuse.
Indiana Health Group will not condition my treatment whether I provide authorization for the requested use or disclosure.
A copy of this authorization shall be as valid as the original.
I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
I have the right to refuse to sign this authorization.
I have the right to receive a signed copy of this authorization.
Indiana Health Group reserves the right to charge for the reproduction of Medical Records in accordance with state law code 760 IAC 1-71-3.

THIS IS A LEGAL DOCUMENT. Please read and complete carefully. By your signature below you agree that you understand & agree to the terms.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized representative may sign and date the form.
Please indicate your legal authority and include documentation: ☐ Legal Guardian ☐ Health Care Agent (Health Care Power of Attorney)
- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature *(Required)* ________________________________ Date Signed *(Required)* ____________

Printed Name of Person Signing this ROI: _ ____

INDIANA HEALTH GROUP USE ONLY

Received and Reviewed By: ________________________________ DATE: __________

Release was Processed By: ________________________________ DATE: __________
Description of Processing: ____

703 Pro-Med Lane ▪ Carmel, IN 46032 Phone 317.843.9922 Fax 317.581.3918 **www.indianahealthgroup.com**