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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ Maiden/Previous: _____

Social Security #: _____ - _____ - _____ Telephone: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

I herby authorize and consent to disclosure of health records as stated below. I am aware that the records disclosed might be records whose confidentiality is protected by either Federal Regulations (42 C. R. F., Part 2) or State Regulations (1C 16-39-16). The records may include alcohol and or substance abuse and mental health documentation as well as HIV results.

- 1. Information to be disclosed (dates of service): _____
[] Office Visit / Progress Notes
[] Laboratory Reports
[] Radiology Reports (X-Ray, CT, MRI, etc.)
[] EKG / Cardiac Testing
[] Other:

I authorize the release of information protected by Federal and State Regulations including alcohol/substance abuse, mental health documentation, and HIV results.

Patient Signature: _____ Date: _____

I understand there will be a charge for the copy of these records as follows: \$15.00 copy fee which includes first through tenth pages, \$0.25 per additional page plus postage fee. Please add \$10.00 for expedited request. \$ _____ total fee due.

Patient Signature: _____ Date: _____

2. I authorize: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax#: _____

To release information to: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax#: _____

3. The purpose or need for this disclosure is: _____

4. This authorization is valid for as long as reasonably necessary to fulfill the purpose for which it is given. This will not exceed 60 days.

5. This authorization may be revoked at any time, except to the extent that action has already been taken.

6. Information to be released in the following manner. Please circle all that apply:

Verbally Photocopy Faxed

Signature of Patient: _____ Date: _____