Indiana Neuroscience Associates
PO Box 501970
Indianapolis, IN 46250
(877) 577-3668 or (317) 570-7900

I, Patient Name: _____, Date of Birth: _____, Address: _____, hereby authorize Indiana Neuroscience Associates to:

☐ Receive the following protected health information from: ☐ Disclose the following health information to:

Name of organization: _____
Street address: _____
City: _____ State: _____ Zip: _____
Phone No.: _____ Fax No.: _____

The following information may be used or disclosed:

☐ Office Records ☐ History & Physical ☐ Discharge Summary
☐ Tests & X-rays ☐ Lab Work ☐ Consultation Report
☐ ER Report ☐ OR Report ☐ In-patient ☐ Out-patient
☐ Other: _____.

Treatment Dates: from _____ to _____.

This protected health information is to be used and/or disclosed for the following purposes:
_____
_____ and will expire on _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Indiana Neuroscience Associates. I understand that a revocation is not effective to the extent that Indiana Neuroscience Associates has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Indiana Neuroscience Associates will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that 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).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Please fax Release of Information back to (317) 570-2286. Should you have any questions, please feel free to contact us at (317) 570-7900. Thank you.