

IUPUI HEALTH SERVICES
AUTHORIZATION TO RELEASE MEDICAL
INFORMATION



OCCUPATIONAL
HEALTH SERVICES

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ S.S.#: _____

Telephone #: _____

I hereby request and authorize:

IUPUI HEALTH SERVICES
1140 W. MICHIGAN STREET
INDIANAPOLIS, IN 46202
PHONE: 274-5887 FAX: 274-7657

To furnish medical records to: Self or fill out the item below

Name of Facility: _____

Address: _____

Telephone #: _____ Fax #: _____

Please release the following information:

Immunization Record TB Skin Test Lab Results

Complete records Other _____

Note: Records that do not originate from visits at IUPUI Health Services **will not** be copied. The patient is responsible for getting copies from the facility that initiated the medical document. The first copy of a patient's immunization record is free, as are records sent directly to clinic or medical facilities. There is a minimum charge of five dollars (\$5) for subsequent copies of medical records requested within a 12 - month period.

I understand that this authorization is subject to written revocation at any time except to the extent that action has been taken based upon it. I also understand that the authorization will expire in one (1) year from the date signed unless I specify otherwise..

Date: _____

Signature: _____

(Patient)

1140 West Michigan Street
Indianapolis, Indiana
46202-5118

Copies of records will be provided within ten business days upon receipt of the request

317-274-5887
Fax: 317-274-7657

IUPUI HS use only

02/20/2007

Sent _____ Not Sent _____

Initial _____ Why _____