AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

SICHC
PO BOX 270
PAOLI, IN 47454
P (812) 723-3944, F (812) 723-7989

MATTHEW MAIN, MD
VINCENT WALDRON, MD
YOLANDA YODER, MD
SHANNON DOOLEY, FNP

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

PREVIOUS NAME: _____ **LAST 4 DIGITS OF SS#:** _____

I REQUEST AND AUTHORIZE: _____
(NAME OF DOCTOR OR FACILITY)

FAX#: _____ **PHONE#:** _____
TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

NAME: SICHC, PO BOX 270, PAOLI, IN 47454, FAX # (812) 723-7989

PREFERRED METHOD TO TRANSFER RECORDS: x **PAPER** ☐ **CD**

THIS REQUEST AND AUTHORIZATION APPLIES TO:
☐ ALL HEALTHCARE INFORMATION
☐ HEALTHCARE INFORMATION RELATING TO THE FOLLOWING TREATMENT OR CONDITION OF DATES: _____
_____
☐ OTHER: _____
•PURPOSE OF DISCLOSURE: CONTINUITY OF CARE
understand that I may revoke this release at any time, in writing but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first. I also understand that this release may include medical records of treatment for physical and/or mental, emotional illness (including treatment of alcohol and/or substance abuse.) I also understand that HIV, AIDS, and/or any sexually transmitted disease might also be released. **My signature below indicates my understanding that once my records have been transferred to another office I will no longer be considered a patient of SICHC in Paoli. If at a later date I choose to return it will be scheduled according to the "New Patient" scheduling criteria.**

_____
PATIENT SIGNATURE DATE

_____
PARENT/GUARDIAN SIGNATURE DATE

_____
WITNESS DATE