FOR OFFICE USE ONLY
Acct # _____
MD _____
Date Received _____
Initials _____

Indiana Hand to Shoulder Center

RELEASE OF INFORMATION
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

1. By signing below, I hereby authorize my health information (referred to as "Protected Health Information"), to be used or disclosed. The Protected Health Information I am authorizing for use or disclosure is the following:
   - ☐ "Standard" release of information (includes typed dictation and therapy notes).
   - ☐ Specific information from the chart which includes: _____
   - ☐ X-ray(s):_____
   - ☐ Information necessary for the completion of FMLA and/or Disability documents.
2. I hereby request Hand Surgery Associates to make the use or disclosure of my Protected Health Information to the following person(s) or institution(s) **for FMLA and/or Disability document completion:**

   Name/Institution:_____ Name/Institution:_____
   Address: _____ Address: _____
   _____ _____
   Fax Number: _____ Fax Number: _____
3. The specific person or group of people who are authorized to use or disclose my Protected Health Information include: any healthcare provider and/or employee of the Indiana Hand to Shoulder Center.
4. This authorization will expire 60 days from signing, unless an earlier date is indicated: _____
5. I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if
   - Hand Surgery Associates has taken action in reliance upon this Authorization;
   - or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.
6. I understand that I may revoke this Authorization by sending a written request to:
   Indiana Hand to Shoulder Center
   8501 Harcourt Road, Indianapolis, IN 46260
   Attention to: RELEASE OF INFORMATION
7. I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization. **Please mail this form to the address listed in number (6) or fax it to 317-872-1328 (attention to: Release of Information).**

_____ _____
Signature (Patient) Date Signature (Authorized Representative) Date

_____ Description of Authorized Representative's
Printed Name (Patient)
authority to sign for the patient:_____

_____ _____ _____
Patient's telephone # Patient's Date of Birth

_____
Signature (Witness) Date