Northeast Medical Associates, PC

1234 E. Dupont Rd. Ste. 6, Ft. Wayne, IN 46825-1545
Phone- 260.480.2600 Fax- 260.496.8077

Release Records to Northeast Medical Associates

Name (Print) _____

Date of Birth_____/_____/_____ Social Security_____/_____/_____

RELEASE RECORDS FROM: _____

Address/Phone Number/ Fax: _____

_____

RECORDS REQUESTED

☐ Labs ☐ X-Rays ☐ Consults ☐ Progress Notes ☐ All
☐ Other _____
_____

PURPOSE OF RELEASE

☐ Medical Care ☐ Insurance ☐ Patient Request
☐ Other, please explain _____
_____

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

I do _____ do not _____ authorize this information to be released. **(You must initial one.)**

Limitations, if any _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization 60 days from the date signed unless otherwise stated herein.

_____ Date: _____/_____/_____
Signature of Patient/Legal Representative

Printed Name (If not the same as patient) _____

Relationship to patient _____