IUPUI

CAMPUS HEALTH

INDIANA UNIVERSITY-PURDUE UNIVERSITY
Indianapolis

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Telephone: _____

I hereby request and authorize:

IUPUI CAMPUS HEALTH
1140 WEST MICHIGAN STREET
INDIANAPOLIS, INDIANA 46202
PHONE: 317-274-8214
FAX: 317-274-7657

To furnish medical records to: □ **Self or complete the information below**

Name of Facility: _____

Address: _____

Telephone: _____ Fax: _____

Please release the following information:
( ) Immunization records ( ) TB tests ( ) Lab results ( ) Progress notes
( ) Outside records ( ) Other _____

Note: The first copy of an immunization record is free, as are records sent directly to a clinic or medical facility. Additional copies of records are subject to a $5.00 minimum charge.

I UNDERSTAND THIS AUTHORIZATION IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN BASED UPON IT. I ALSO UNDERSTAND THIS AUTHORIZATION WILL EXPIRE 60 DAYS FROM THE DATE SIGNED. IUPUI CAMPUS HEALTH HAS UP TO 10 DAYS TO SEND THE REQUESTED RECORDS TO THE DESIGNATED PROVIDER/FACILITY.

Signature: _____ Date: _____
(Patient)

Records sent by: _____ on _____
(Staff initials) (Date)

Reason records were not sent: _____ _____
(Date)

A 4.1 Attachment A
Revised 3/10/2016