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:

Name of Facility: _____ Telephone: _____

Address: _____ Fax: _____

To furnish medical records to: IUPUI CAMPUS HEALTH
1140 West Michigan Street
Indianapolis, IN 46202
Phone: (317)274-8214
Fax: (317) 278-6929

Please release the following information:
( ) immunization records
( ) complete records
( ) x ray/MRI/CT/US reports
( ) pathology reports
( ) consultation visits
( ) discharge notes
( ) outpatient reports
( ) laboratory reports
( ) other _____

I UNDERSTAND THIS AUTHORIZATION IS SUBJECT TO WRITTEN REVOCATION AT ANY TIMES EXCEPT TO THE EXTENT OF ACTION THAT HAS BEEN TAKEN BASED UPON IT. I ALSO UNDERSTAND THIS AUTHORIZATION WILL EXPIRE 60 DAYS FROM THE DATE SIGNED.

Signature _____ Date: _____
(patient)

Signature: _____/ _____
(parent/guardian if patient is a minor) (relationship)

Record request faxed by:_____ on _____
(staff initials) (Date)

Revised 2/18/16