



**IUPUI**  
CAMPUS HEALTH

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_  I authorize that the medical information can be sent electronically.

Purpose of Release \_\_\_\_\_

I hereby request and authorize:

IUPUI CAMPUS HEALTH  
1140 W. MICHIGAN STREET  
INDIANAPOLIS, IN 46202  
PHONE: (317) 274-8214 FAX: (317) 274-7657

To furnish medical records to:  Self or fill out the item below

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ Fax#: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Please release the following information:

- Immunization Record                       TB Test                                               Lab Results
- Complete Record                               Other \_\_\_\_\_

Records that do not originate from visits at IUPUI Campus Health usually will not be copied, unless the patient cannot obtain it from the original source and it is specified on the form. The patient is responsible for getting copies from the facility that initiated the medical document. There is a minimum charge of ten dollars (\$10) for first 10 pages and .25 per page for each subsequent page. Records sent directly to clinic or medical facilities are free.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released.

- Alcohol, drug or substance abuse records       Yes                       No
- HIV testing or results                               Yes                       No
- Mental health records                               Yes                       No

I understand that this authorization is subject to written revocation at any time except to the extent that action has been taken based upon it. I also understand that the authorization will expire in 60 days date signed unless I specify otherwise.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

IUPUI CH use only:

Date Sent: \_\_\_\_\_ Name: \_\_\_\_\_  
Not Sent: \_\_\_\_\_ Name: \_\_\_\_\_ Reason not sent: \_\_\_\_\_