Health and Wellness of Carmel, LLC
11900 N Pennsylvania St., Ste 200
Carmel, IN 46032
www.hwofc.com

Authorization to Disclose Health Information

Patient Name: ______________________________ Date of Birth: ______________
Social Security Number: ______________________ Phone #: ______________________
Address: ____
(Street) (City) (State) (Zip Code)

This information may be disclosed by the following individual or organization:
Name: ____
Address: ____
Phone #: ______________________ Fax #: ______________________________

INFORMATION TO BE RELEASED:

- o Entire Record
- o Laboratory Reports
- o Office Note Dictation
- o Radiology/ Imaging Reports
- o Office Note Dictation
- o Immunizations
- o Other ______________

Specific Dates if Applicable: ______________________________

This information may be disclosed to end used by the following individual or organization:
Name: Health & Wellness of Carmel, LLC
Address: 11900 N. Pennsylvania St., STE 200, Carmel, IN 46032
Phone #: 317-663-7123 Fax #: 317-587-0496
For the purpose of ____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, as provided in CFR 164.524. I understand that if I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of the form upon request. I understand that this release also pertains to my medical records concerning treatment, including but not limited to, information regarding treatment for alcohoVsubstance abuse, communicable diseases, including AIDS or human immunodeficiency virus (HIV), and/or psychiatric or mental health problems. I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing and present my written withdrawal to the health information management department of the entity listed above. I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will expire on the following date, event, or condition specified below.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Health and Wellness of Carmel, LLC at (317) 663-7123.

If I fail to specify an expiration date, event or condition, this authorization will expire in sixty (60) days. __________

______________________________ ______________
Signature of Patient or Legal Representative Date

______________________________ ______________
(If signed by Legal Representative, state relationship and authority to do so) Signature of Witness

Patient is: Legal Authority:	o Minor	o Incompetent	o Authorized Legal Representative
	o Custodial Parent	o Disabled	o Power of Attorney for Healthcare
	o Legal Guardian	o Deceased	o Executor of Estate of Deceased