

**INDIANA WESLEYAN UNIVERSITY HEALTH CENTER**

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**PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_  
number street apt. # city state zip

Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_

I authorize Indiana Wesleyan University Health Center to disclose/obtain medical information of the above named individual as described below:

\_\_\_\_\_ Chart notes                      \_\_\_\_\_ Lab results                      \_\_\_\_\_ ER Records  
\_\_\_\_\_ Medication(s)                      \_\_\_\_\_ Test(s)/Procedure(s)                      \_\_\_\_\_ Mental Health Records  
\_\_\_\_\_ Immunization Record                      \_\_\_\_\_ Other \_\_\_\_\_

Information to be obtained from/disclosed to: \_\_\_\_\_  
name of agency

\_\_\_\_\_ address city state zip

\_\_\_\_\_ phone number fax number

I understand the information may be communicated via fax, photocopy, verbal communication, telephone, voice mail, and/or direct mail.

The information being disclosed/obtained is for the following purpose: \_\_\_\_\_

I understand that I may revoke this release at any time in writing except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date below. I also understand that this release may include medical records of treatment for physical and /or emotional illness, including the treatment of alcohol or drug abuse. HIV, AIDS or AIDS-related and/or communicable disease information may also be released.

Expiration date of authorization: \_\_\_\_\_  
(enter date of expiration ONLY if other than 1 year)

Signature of patient(if over 18) \_\_\_\_\_ date \_\_\_\_\_

Signature of parent/guardian (if patient is under 18) \_\_\_\_\_ date \_\_\_\_\_  
Signature relationship

Witness \_\_\_\_\_

