Anesthesia Pain Consultants of Indiana
8240 Naab Road, Suite 101
Indianapolis, IN 46260
Office: 317-471-1400
Fax: 317-471-1900

Patient Authorization for Disclosure to Designated Provider

Form 7.32

Please print all information, then sign and date form at bottom

Patient Name: _____

Social Security Number: _____ ***Date of Birth:*** _____

Purpose of request - I request and authorize the disclosure or release of my protected health information (as identified below) to the following provider:

_____
Name of practice who will receive information

_____
Name of provider

_____
Address

_____
City, State, Zip

_____ _____
Phone Fax Number

Practice or provider maintaining original information: _____

Description of information to be disclosed - I authorize the disclosure of the following protected health information about me to the provider identified above:

☐ Complete medical record; or the following limited information (provide description):

_____

_____

Purpose of disclosure: (please list the purpose of the disclosure or check patient request):

_____ ☐ Patient Request

- ***Expirations or termination of authorization:*** This authorization will expire within 14 days from the date of my signature below.
- ***Right to revoke or terminate:*** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization.
- ***Non-Conditioning statement:*** The practice places no condition to sign this authorization on its' delivery of healthcare or treatment.
- ***Redisclosure:*** We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_____ _____

Patient signature Date

Copies of signed authorizations are available upon request.