Jeffrey M. Blake, M.D., Inc.
141 W. 22nd Street, Suite 309
Anderson, IN 46064
Tel: 765-646-8569 Fax: 765-622-9708

Authorization for Release of Information

Patient Name:_____ Date of Birth:_____
Social Security Number:_____

I authorize Jeffrey M. Blake, M.D., Inc. to (circle one) OBTAIN my health information or to RELEASE my health information as described below.

Please provide this information in the following format: __ Printed Copy __Electronic (CD)

_____ Please release my entire record.

_____ Please release only the following information:

__ Problem List
__ Medication List
__ List of allergies
__ Immunization records
__Other:_____

__Most recent history
__Most recent discharge summary
__Lab results (list dates/types): _____
__X-Rays & Imaging reports (lists dates/types):_____

Initial each item below to indicate your understanding.

____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used or released to the following individual(s) or organization(s):

Name:_____ Name:_____
Address:_____ Address:_____

This authorization will expire on: _____ If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date of which it was signed.

_____ ___/____/_____
Patient Signature (or Signature of Person Completing the form if not the patient*) **Date**

*Relationship to patient: ____Parent ____Guardian ____Other:_____

_____ ___/____/_____
Witness Signature Date