Indiana University Health Center
Financial Operations
Release of Information
600 N. Jordan Ave.
Bloomington, IN 47405
Phone: (812) 855-2575
Fax: (812) 855-4628

_____
Last Name, First, MI

_____
University ID Number

I hereby authorize the IU Health Center to furnish any and all information required to the party noted below regarding PHYSICAL health, MENTAL health and PHARMACY services provided to me by the IU Health Center. Please provide dates or time period below. (Cannot include future dates.)

_____ Is this: **Service Date** OR **Bursar Billing Date**? Circle one.

Release to:

_____Patient

_____Parent

Name and Address: _____

_____

_____

_____

OR

FAX: _____

I understand that I may revoke this authorization at any time in writing, but that the authorization shall remain valid until revoked. An emailed, scanned or photocopy of this authorization may be used in place of the original. I hereby state that I am competent and that I fully understand the terms of this release.

Signature of Patient: _____ Date signed: _____

Patient Address: _____ Phone number: _____

_____

Notes:_____

_____

_____

_____