Indiana University Health Center
600 North Jordan Avenue
Bloomington, IN 47405-3191
Phone: (812) 855-4970
Fax: (812) 855-4245

Authorization for Release of Information

I, _____, _____
Patient's Full Name *University Identification # (UID) & Date of Birth*

hereby authorize the Indiana University Health Center to release from my medical record the following identified health information:

____My **ENTIRE** Medical Record: including, but not limited to, mental health; psychiatric; drug or alcohol abuse; human immunodeficiency virus (HIV); acquired immunodeficiency syndrome (AIDS); AIDS related complex (ARC); and communicable diseases.

____The following specific portion(s):
_____
_____
_____
_____
_____
_____

The above information may be released to:

Name of person/organization: _____
Street Address: _____
City/State/Zip Code: _____
Phone Number: _____

The information is being authorized for release for the following reasons:

_____
_____

I understand that I may revoke this Authorization in writing except to the extent action has been taken in reliance thereon. If revoked, it is understood by all affected parties that all health information released prior to being notified of such revocation was made with my authorization. The request shall remain valid unless revoked in writing.

I understand that IU Health Center cannot condition medical or psychological treatment on obtaining this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this authorization.

I further agree to pay to the IU Health Center the appropriate fees in accordance with Indiana law, I.C. 16-39-9 or other applicable law.

Records on clients seen in our Counseling and Psychological Services and Sexual Assault Crisis Service are maintained separately and require a separate authorization and should be directed to those units.

By signing this Authorization for Release of Information, I acknowledge that I have read and fully understand the terms and conditions of this authorization.

_____ _____
Patient's Signature Date

_____ _____
Address Telephone Number