Associates for Women's Health
533 E. County Line Rd., Suite 102
Greenwood, IN 46143
Phone: 317-859-6626 Fax: 317-887-4691
Tessa Asdell, M.D., Soheila Boyer, D.O., Swati Jain, M.D.

Authorization for Release of Protected Health Information

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Telephone: _____

CIRCLE ONE: Dr. Tessa Asdell Dr. Soheila Boyer Dr. Swati Jain

I hereby authorize and consent to disclosure of health records as stated below. I am aware that the records disclosed might be records whose confidentiality is protected by either Federal Regulations (42 C.R.F., Part 2) or State Regulations (I.C. 16-39-16). The records may include alcohol and/or substance abuse and mental health documentation as well as HIV results.

1. Information to be disclosed (dates of service): _____
   - ❑ Office Visit/Progress Notes
   - ❑ Laboratory Reports
   - ❑ Radiology Reports (x-ray, CT, MRI, etc.)
   - ❑ EKG/Cardiac Testing
   - ❑ Other: _____
   - ❑ I authorize the release of information protected by Federal and State Regulations including alcohol/substance abuse, mental health documentation, and HIV results.

2. I authorize:

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TO OBTAIN FROM OR RELEASE INFORMATION TO

Name: _____

Address: _____

_____

Phone number: _____ Fax number: _____

3. The purpose or need for this disclosure is _____
   Are you leaving the practice? If so, why? _____

4. This authorization is valid for as long as reasonably necessary to fulfill the purpose for which it is given. This will not exceed 60 days.

5. This authorization may be revoked at any time, except to the extent that action has already been taken. To revoke this authorization, I will notify the Privacy Contact in writing.

6. Information to be released in the following manner:
   ❑ Verbally ❑ Photocopy ❑ Faxed

7. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

8. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

   I agree to pay the cost (set forth by Indiana ISA Document #05-26[F]) incurred in copying the medical records. A flat fee of $20.00 for the first 10 pages or less, 50 cents for pages 11 through 50, 25 cents for pages 51 and higher plus the cost of postage. An additional fee of $10.00 for requests to be provided within 2 working days.

_____ _____
Signature of Patient or Personal Representative Date

If Personal Representative:

_____ _____
Name of Personal Representative Description of Representative's Authority to Act for the Patient