# AUTHORIZATION TO USE OR DISCLOSE INFORMATION

Meridian Plastic Surgeons / Meridian Plastic Surgery Center
170 W. 106th St. Indianapolis, IN 46290 Fax: (317) 571-8667 Phone: (317) 575-0330

I hereby authorize the use or disclosure of my individual identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization or persons authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**PATIENT**: ______________________________________________

Last | First | MI | Date of Birth

______________________________________________

Street Address | City | State | Zip | Phone

## RELEASE MY INFORMATION

☐ TO:
☐ FROM:

Meridian Plastic Surgeons / Meridian Plastic Surgery Center
170 W. 106th St. Indianapolis, IN 46290 Fax: (317) 571-8667

☐ TO:
☐ FROM:

______________________________________________

Name of Person/Organization Receiving/Sending my Information | Phone#

☐ EMAIL ______________________________________________

*Please note, some files may be too large to email, please provide an additional option

☐ FAX # ______________________________________________

☐ MAIL ______________________________________________

Street Address | City | State | Zip

- **THIS AUTHORIZATIOIN APPLIES TO THE FOLLOWING INFORMATION:**

☐ **All Records (Office Notes, Operative Reports, & Labs)**
☐ **Office Notes**
☐ **Operative Reports**
☐ **Labs**
☐ **Itemized Billing Statement**
☐ **Narrative Report ($400.00)**
☐ **Photos ($7.00/each printed page)**
☐ **Other** ____________________

- **PURPOSE FOR THIS DISCLOSURE (PLEASE SPECIFY):**

______________________________________________

- **A SPECIFIC AUTHORIZATION IS REQUIRED TO RELEASE INFORMATION REGARDING THE FOLLOWING:**

| | | | INITIALS |
|---|---|---|---|
| HIV Information | YES | NO | ______ |
| Drug/Alcohol Information | YES | NO | ______ |
| Mental Health Information | YES | NO | ______ |

I understand that I am required to pay an initial fee of $5.00 (includes first five pages) and then 25 cents/page thereafter plus postage. After a significant amount of time, the records are housed out of office. Retrieval of archived records, if located, adds an additional $18 charge. I understand that I will not be denied health care or health plan coverage, as the case may be, if I do not sign this form. I understand that I may request a copy of this form. I understand that I may revoke this authorization at any time by notifying the person or organization providing the information in writing, but if I do, it will not affect any actions taken before the revocation is received.

Please indicate a date after which no information can be released ____________________. If no date is given, authorization is valid for one year.

______________________________________________ ____________________

**Signature of Patient or Patient's Representative** **Date**

______________________________________________ ____________________

**Printed name of Patient's Representative** **Relationship to Patient**

**FOR OFFICE USE ONLY**

Completion Date: ____________________ Processed By: ____________________ Initial: ____________