HEALTH RECORDS REQUEST RELEASE AUTHORIZATION

PLEASE FILL OUT THE FORM COMPLETELY

Patient Name (Please Print)_____ Date_____
Last Name/First Name/M.I./Maiden(if applicable)

Social Security #_____-_____-_____ Birth Date _____/_____/_____
Month Day Year

Current Address_____
City_____State_____Zip_____
Phone#(_____)_____ Cell#(_____)_____

I HEREBY AUTHORIZE DR. KOCHERT PAIN & HEALTH TO RELEASE MY HEALTH RECORD(S) TO: Providers Name: _____ Providers Address:_____ _____ _____ Fax Number: _____	I HEREBY AUTHORIZE _____ TO RELEASE MY HEALTH RECORD(S) TO: Provider's Name: Dr. Kochert Pain & Health Providers Address:3218 Daugherty Dr., Suite 110 Lafayette, IN 47909 Phone 765-446-5055 Fax 765-446-5057

Purpose for release:_____

The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases, pregnancy, and HIV/AIDS.

PLEASE CHECK APPLICABLE REQUEST:

___**ALL** Health Records(s) (may include mental health, drug or alcohol use/abuse, communicable diseases, pregnancy and HIV/AIDS)
___Only pregnancy related information from_____to_____
___Only gynecological information from_____to_____
___Only X-rays/lab results from_____to_____
___Only prescriptions from_____to_____
___Other-Please specify information to be released:_____
_____

This Authorization shall expire ninety (90) days from the date of its execution or upon my express revocation whichever occurs earlier. Such revocation shall become effective immediately, except to the extent that Unity Healthcare, LLC has taken actions in reliance on it.

_____ _____ _____ _____
Patient Signature Date Parent/Guardian Signature Date

Record released by:_____ Date:_____