AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS

I hereby authorize the physicians or employees of _____ to forward my medical records.
(Doctor/Clinic)

DURATION: ***Authorization shall be effective immediately and remain in effect for one year.***

REVOCATION*: Written revocation will be effective upon receipt*.

SPECIFY RECORDS:

***Check the box* and *initial* which type of information to be disclosed:**

□_____**All MEDICAL RECORDS -** By checking this box you authorize HCP/MED-R to disclose the following information: HIV/AIDS and STD'S results and or diagnosis, Drug and Alcohol Abuse, Behavioral/Mental Health Treatment, Sexual Assault, Child/Adult Abuse, Genetic testing, and Psychiatric notes.

□_____**MEDICAL INFORMATION** □_____**ADD /ADHD** □_____**XRAY COPIES ON CD**

□_____**PSYCHIATRIC NOTES** □_____**DRUG/ALCOHOL TREATMENT**

□_____**HIV/STD TEST RESULTS** □_____**BEHAVIORAL /MENTAL HEALTH TREATMENT**

Please provide records in the following format:

□ **paper record** □ **disk** ☒ **e-mail** service@hoosierservicesinc.com
(email address)

PLEASE PROVIDE RECORDS FROM THE FOLLOWING SERVICE DATES:

_____

RELEASE MEDICAL RECORDS FROM:

Doctor/Clinic_____

Address: _____

CITY/STATE/ZIP: _____

TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

FORWARD MEDICAL RECORDS TO:

Doctor/Clinic/Patient: Hoosier Services Inc.

Address: 18032 Lemon Dr.,#C-618

CITY/STATE/ZIP: Yorba Linda, CA 92886

TELEPHONE NUMBER: 800.882.4156 **FAX NUMBER:** 800.882.4957
Email: service@hoosierservicesinc.com

Patient Name: _____ ***Date of Birth:*** _____

Patient Signature: _____ ***Date:*** _____
Parent/ Legal Guardian or Authorized Representative

Patient Phone #: _____ ***Patient Email:*** _____