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PATIENT INFORMATION RELEASE

Patient Name (Last – First – Middle)		Previous Last Name (if any)	
Street Address	City	State	Zip Code
Birthdate	Telephone Number	Social Security Number	

PROVIDER	REQUESTOR
Who has the information you would like released?	**To Whom should the information be sent?**
☐ **Fort Wayne Physical Medicine** ➡	**Address:**
☐ Name:	**FWPM** **5750 Coventry Lane** **Fort Wayne, IN 46804** Attention:

RELEASED INFORMATION SHOULD INCLUDE:

_______ The entire medical record relating to the diagnosis and treatment of: _______
_______ The following specific portions: _______
_______ The following specific dates: _______
_______ EEG Reports _______ MRI Scans
_______ CT Scans _______ Lab Results

I, the undersigned, hereby authorize the **provider** to release to the **requestor** the information from my medical record concerning any diagnosis, treatment or prognosis as described above. This also includes but is not limited to information regarding treatment of drug or alcohol abuse, psychological conditions, HIV testing, AIDS or an AIDS related condition.
I understand and agree that if the physicians involved with my care reasonably determine that the information requested is detrimental to my physical or mental health, or is likely to cause harm to myself or another, he/she may withhold the information from me.
I understand that this consent is valid for sixty (60) days from the date below, and that I may revoke authorization at any time during the sixty (60) day time period by written notification to the **provider**.
I hereby state that I have read and fully understand the above statements as they apply to me.

Patient Signature: _______ **Date:** _______
Witness Signature: _______ **Date:** _______

This authorization must be signed by the patient. In case of a minor patient, this authorization must be signed by a parent or guardian. In the case of a patient who is physically unable to sign this authorization, he/she should place an “X” on the signature line and have his/her assent witnessed. In the case of a patient who has been declared mentally incompetent, this authorization may only be signed by a legally appointed guardian. In the case of a deceased patient, this authorization must be signed by the executor/administrator of the estate.

Signature other than patient: _______ **Date**: _______
Relationship to patient: _______
Reason patient unable to sign: _______