**I give HealthNet consent to release the medical records of:**

Last name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_\_

Last 4 digits of Social Security # \_\_ \_\_ \_\_ \_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **I give HealthNet consent to release these medical records to:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_   
 **With the following information from: this date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ **to** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_.  
 Provider notes  Billing records  Labs/X-Ray  Ultrasound  Immunizations (Shots)  Other tests/records \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Consultations  Entire medical record  
 **Special Consent Section:** *(Per IC-16-39-2. This special permission is valid for 180 days.)*  
 Behavioral Health/Counseling records  Communicable disease testing (like STIs)   
 HIV results  Genetic records  Alcohol, drug, or substance abuse records

**For the purpose of:**  Continued Care  Shots/School  Legal  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Method requested *(check one):***  Paper  CD/Electronic format  Verbal  
 E-Delivery *(secure link)* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I give my consent for HealthNet to release my medical records as described above and I know:**

1. If my record contains any highly private information like HIV tests or counseling records, I must check the correct box(es) above for HealthNet to release these sections.
2. To stop the release of this information, I must write a letter to the address below. Canceling the release will not apply to records that have already been sent.
3. This authorization will expire in 60 days unless I state a different date here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. The person/organization that receives my records may not have to follow federal privacy laws like HealthNet. Once HealthNet releases my records, HealthNet no longer has control over what that person/organization does with my records.
5. HealthNet will treat me even if I do not sign this form.
6. I must completely fill out this form for HealthNet to release my records.
7. If I request an electronic format, I can receive my medical records on a CD or E-Delivery.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of person completing form

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Signature of Patient/Legal Representative Date Relationship to Patient

**Staff Use Only:** Received by:  Email  Fax  Mail  In Person (name of staff who witnessed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_