**I give HealthNet consent to obtain 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 obtain these medical records from:**

Provider 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  **Method requested *(check one):***  Paper  CD/Electronic format  Verbal

 E-Delivery *(secure link)* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of person completing form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Send my records to:**

**Fax Number:**

\_\_\_\_ Barrington Health & Dental Center 3401 E. Raymond Street Indianapolis, IN 46203 317-957-2120  
\_\_\_\_ Care Center at the Tower 1633 N. Capitol Ave., Suite 500 Indianapolis, IN 46202 317-275-3655  
\_\_\_\_ Homeless Initiative Program 2944 Cliffton St. Indianapolis, IN 46208 317-957-2280  
\_\_\_\_ Martindale-Brightwood Health Center 2855 N. Keystone Ave., Suite 100 Indianapolis, IN 46218 317-957-2320  
\_\_\_\_ Northeast Health Center 3908 Meadows Drive, Suite 1 Indianapolis, IN 46205 317-957-2160  
\_\_\_\_ Pediatric & Adolescent Care Center 1633 N. Capitol Ave., Suite 236 Indianapolis, IN 46202 317-275-3640  
\_\_\_\_ People’s Health & Dental Center 2340 E. 10th Street Indianapolis, IN 46201 317-957-2221  
\_\_\_\_ Southeast Health & Dental Center 901 Shelby Street Indianapolis, IN 46203 317-957-2420  
\_\_\_\_ Southwest Health & Dental Center 1522 W. Morris Street Indianapolis, IN 46221 317-957-2520  
\_\_\_\_ West Health Center 6029 W. 10th Street Indianapolis, IN 46224 317-275-3635

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