MEDICAL RECORD REQUEST

Please fill out the form completely. Fax or Mail Release to:

Medical Records Release
550 Landmark Ave
Bloomington, IN 47403
Phone: 812-355-6961
Fax: 812-355-3269

Patient Name: (*Please print)* _____ ***Last name*** ***First Name*** ***Middle Initial***	**Patient Phone # :** _____
Social Security #: _____ _____ _____	**Date of Birth:** ***Month*** _____ ***Day*** _____ ***Year*** _____
Patient Address: _____ ***City*** _____ ***State*** _____ ***Zip*** _____	

I authorize Premier Healthcare, LLC to RELEASE my records to:	**I authorize Premier Healthcare, LLC to RECEIVE records from:**
Name:	**Name:**
Full Address:	**Full Address:**
Fax #:	**Fax #:**
Phone #:	**Phone #:**

Charges for copies of documents shall be in accordance with OCR Guidelines

Purpose of Release:

- ❑ Specific records from the following dates: _____
- ❑ Continuing medical care. One to two years of current records will be sent.
- ❑ Health Record(s) (to include mental health, drug or alcohol use/abuse, communicable diseases, pregnancy and HIV/AIDS).

Format of Original Patient Record	Cost for delivery in electronic format (CD/USB/download or portal):	Cost for record delivered in Paper
Electronic or Hybrid (part electronic part paper)	• $6.50 flat fee for electronic portion • Plus, if applicable, $0.07 per page to create and deliver the portion of record maintained in paper • Plus sales tax as applicable	• $0.07 per page to create and deliver the portion of record maintained in paper • Plus, if applicable, the lower of cost under state regulated patient rates or $0.90 to create and deliver the portion of record maintained electronically • Plus $0.05 per page for supplies(paper and toner) • Plus actual postage if mailed • Plus sales tax as applicable
Paper	• $0.07 per page to create and deliver the portion of recordmaintained in paper Plus actual postage if mailed • Plus sales tax as applicable	• $0.07 per page to create and deliver the portion of record maintained in paper • Plus $0.05 per page for supplies (paper and toner) • Plus actual postage if mailed • Plus sales tax as applicable

I, the undersigned, understand that I may REVOKE this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of 90 days, whichever occurs first, EXCEPT to the extent that action has been taken. Information used or disclosed may be subject to re-disclosure and no longer protected by the HIPAA rule. I understand that my medical information may include treatment for physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, pregnancy, HIV, AIDS, or AIDS-related information, unless I otherwise restrict such release of information.

Authorization must be signed by the parent or legal guardian of any patient under 18 years of age. Emancipated minors may sign for themselves. The personal representative/executor of estate may sign for a deceased patient's information. If no personal representative/executor, then the spouse, child or sibling may sign.

Patient Signature _____ **Date Signed** _____

Patient/Guardian _____ **Date Signed** _____

Record Released by _____ **Date Signed** _____