8240 Naab Rd, Suite 416
Indianapolis, IN 46260
317-306-5588
www.magnificatfamilymedicine.com

Authorization for Release of Protected Health Information

Patient Name:	***Patient email:***
Date of Birth:	***Phone #:***
Address:	***City, State, Zip Code:***

I hereby request and authorize Magnificat Family Medicine (MFM) to release or obtain the following information contained in my medical records:

Requested From (required):	***Release to:*** *Magnificat Family Medicine, LLC*
Address:	***Address:*** *8240 Naab Rd, Suite 416*
City, State, Zip Code:	***City, State, Zip Code:*** *Indianapolis, IN 46260*
Phone:	***Phone:*** *317.306.5588*
Fax (required):	***Fax:*** *317.550.1544*
Email:	***Email:*** *frontdesk@magnificatfamilymedicine.com*

Please Send Via:
□ Fax *(preferred)* □ Mail □ Email □ Hold for pick up

Purpose of Disclosure:
□ Continuity of Care □ Insurance/billing □ Legal Matter □ Personal □ Other _____

Information to be Released:
□ All Records □ Tissue Reports □ Mental health/counseling records
□ Office Visit/Progress notes □ Operative Records □ Substance abuse treatment records
□ Labs/imaging reports □ Other:_____

Dates of Service(s):
□ All dates of service prior to, and including date of authorization below.
□ Only the following dates of service:_____.

I understand this authorization may be revoked at any time. This authorization will automatically expire in 180 calendar days from the date signed, unless I specify otherwise. I may revoke this authorization at any time by providing notice, in writing to Magnificat Family Medicine. Any revocation will bear no effect on any actions taken prior to the date my revocation is received and processed by Magnificat Family Medicine. I understand that my health information may be subject to re-disclosure by the authorized recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the Federal Privacy Regulations, and that Magnificat Family Medicine is not responsible for this action.

I hereby affirm that I have read and fully understand the above statement and the entirety of this authorization.

Patient/Guardian Signature:_____Date:_____

Relationship to Patient: _____