Hancock Physician Network

RECORDS TO BE RELEASED FROM:

Hancock Physician Network, LLC
Corporate Office: 156 W. Muskegon Drive
Greenfield, IN 46140

I hereby request and authorize Hancock Physician Network, LLC ("HPN") to furnish records to:

Name/Organization_____

Address _____

City, State, Zip _____

I prefer to have said records released via ◯ electronic means or ◯ paper, please select one.

Please release my records from the following practice:

□ Anderson Family Practice	□ Hancock Physician Network-Fortville
□ Hancock Pediatrics	□ Hancock Family Practice
□ Northeast Medical Group-Greenfield	□ Northeast Medical Group-McCordsville
□ New Palestine Family Medicine	□ Hancock Counseling & Psychiatric Services
□ Hancock Immediate Care-Greenfield	□ Hancock Immediate Care-McCordsville
□ Hancock Immediate Care-Morristown	□

Patient Full Name: _____

Address: _____

City, State, Zip_____

Date of Birth _____Telephone # ( ) _____ Social Security _____

Please release the following information:

□ HPN Provider Notes	□ HPN X-Ray Reports
□ HPN Special Diagnostic Test Results	□ HPN Chemical/Alcohol Treatment Records
□ HPN Lab Reports	□ All Medical Records
□ HPN Billing Records	□ Other (Specify)

Unless **I HAVE LIMITED BELOW**, I understand that this also pertains to records regarding testing and treatment for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or for psychiatric treatment or counseling or communicable disease.

Limitations: _____

- Confine to summary information from records regarding treatment for the following condition or injury: _____
- On or about [date(s)] _____
- Other:_____

I understand (1) I may revoke this authorization at any time, except to the extent that action has been taken based upon it, as described in the HPN Privacy Notice. (2) That this authorization will expire in 60 days from the date signed, unless I specify otherwise. (3) That the recipient of these records may further disclose information because of this authorization and then it may no longer be protected by the Federal Privacy Regulations, and that HPN would not be responsible for this action, and (4) I am entitled to ask for a copy of this document.

Date: _____ Patient Signature_____

Signature: _____
(Parent/Guardian/legal Representative, if patient is unable to sign) **(Relationship)**

I certify that I only want my EHR records copied _____ for a fee of 25.00

I certify that I want both my EHR and paper chart copied _____. There is an additional 40.00 fee for record retrieval.

***This is in compliance with Federal HIPAA guidelines**