

## Authorization to Release Medical Records

Records to be released from	Interventional Pain 5501 W. Bethel Av Muncie, IN 47304	ve.		
I hereby request and authorize the	e above provider to fu	rnish records for	the purpose of	
		or at 1	ny request.	
Records to be sent to: Provide complete name, address, and zip code				
		Phone DOB SS#		
Information that may be released: All records Of Labs I Hi Therapy notes Di Operative Reports Of	ffice Visit Notes story & Physical scharge Summaries _	Consultation Image report	s (MRI, x-ray, etc.)	
I understand that this release health records, and communicable	e disease records, incl	luding HIV and A	AIDS.	
	-	d regarding		
I understand that (1) I may revoke authorization has been taken base information because of this autho Regulations; (3) I am entitled to a authorization and my refusal to si discharge for the release of these	d upon it; (2) that the rization and it may th sk for a copy of this o gn will not affect my	recipient of thes en no longer be p locument; (4) I r ability to obtain	e records may further disclose th protected by Federal Privacy may refused to sign this treatment. There may be a	
Signature of patient or patient rep	resentative			
Description of representative's au	thority to act for patie	ent		
Date signed	_ Expiration: 60 day	s or earlier date of	of	
Authorizations for health recontinan 60 days.	ds as defined by In	diana Statute m	ay not be effective for longer	

5501 W. Bethel Ave. Muncie, IN 47304 With locations in Muncie, Hartford City, Fishers, Upland, and Shelbyville phone: 765-741-2957 toll free: 877-472-5548 fax: 765-747-3310 Download Free Templates & Forms at Speedy Template http://www.SpeedyTemplate.com/