American Health Network

204-IN (2019)
Authorization for Release of Medical & Billing Records
Find us on the web at: https://www.ahni.com

Site ID:

Please note that there may be a charge for providing copies of your medical records as allowed by Federal & State Law

MEDICAL RECORDS OF (PATIENT INFORMATION):

First: _____ Date of Birth: _____

Maiden/Middle: _____

Last: _____ Last 4 digits of SS #: _____

Address: Street Name: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Return Completed Form to:
American Health Network
of Indiana, LLC
Practice Name: _____

Address: _____

or Fax to: _____

Telephone: _____

RECORDS TO BE RELEASED FROM:
American Health Network of Indiana, LLC ("AHN") Practice or physician name & address:

RECORDS TO BE RELEASED TO:
I *(insert name of Patient/patient representative)* _____
hereby request and authorize American Health Network of Indiana, LLC ("AHN") to release my medical & billings records as indicated below to: (Name of person or organization receiving records)

Address: _____
(Street Name) *(City)* *(State)* *(Zip)*

Fax: _____ Telehone: _____ Email: _____

***FORMAT OF DELIVERY:** AHN will provide paper copies of the requested record. You may request an alternative delivery format, and if we are able, we will provide the records in the requested format:*

FOR THE PURPOSE OF *(reason for disclosure):*

☐ Continuing Care	☐ Referral to a Specialist	☐ Change of Doctor/Provider	☐ Personal
☐ Insurance	☐ Workers Comp	☐ Disability Determination	☐ Legal

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continued . . .

INFORMATION TO BE RELEASED: *At my request, release the following information (check those that apply):*

Date(s) of service: From: _____ to: _____ OR, ☐ Last two years

☐ AHN Provider Notes	☐ AHN X-ray Reports
☐ AHN Special Diagnostic Test Results	☐ AHN Chemical/Alcohol Treatment Records
☐ AHN Lab Reports	☐ ALL Medical Records
☐ AHN Billing Records	☐ Other (specify)

SPECIAL LIMITATIONS: **Unless I HAVE LIMITED BELOW**, I understand that the release of records also pertains to those records regarding testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS**, and for **psychiatric treatment or counseling or communicable disease**. Or, Indicate **LIMITATIONS BELOW**:

1. Confine to **summary information** from records regarding treatment for following condition or injury:

   _____ On or about (date(s): _____

2. Other: _____

***Note: AHN has contracted with a third party copy service vendor (CIOX Health) to process requests for, and produce medical records. There may be a charge for providing a copy of your records as allowed by Federal and State Law. Carefully review attached copying fee schedule*

I UNDERSTAND: (1) THAT THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE; (2) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY CALLING OR EMAILING AHN COMPLIANCE OFFICE AT: (317) 580-6448 OR BY EMAIL AT Compliance@ahni.com, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT, AS DESCRIBED IN THE AHN PRIVACY NOTICE; (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 AHN WOULD NOT BE RESPONSIBLE FOR THIS ACTION; (4) I AM ENTITLED TO ASK FOR AND RECEIVE A COPY OF THIS DOCUMENT, AND; (5) I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE HEALTH CARE TREATMENT AND AHN WILL NOT CONDITION TREATMENT, PAYMENT, ON WHETHER I SIGN THIS AUTHORIZATION.

Specify authorization expiration date (if not 60 days) _____

Patiant Signature: _____ Date: _____

Patient Legal preventative: _____
(Name, Relationship to Patient) (Signature) (Date)

For Office Use

Date Received: _____ **Received by:** _____

Date Released: _____ Released by: _____ File: See instructions in policy #203