TULIP TREE
FAMILY HEALTH CARE
WWW.TULIPTREEHEALTH.ORG
812-753-1039
123 N. MCCREARY STREET
FT. BRANCH, IN 47648
108 N. MAIN STREET
PRINCETON, IN 47670

Authorization to Obtain/Release Information

Patient name:_____ Patient DOB: _____

Patient Address:_____ Phone:_____

I authorize records to be sent:

From:_____ Address: _____

Phone Number:_____ Fax Number: _____

To:_____ Address:_____

Phone Number:_____ Fax Number: _____

Format Type: ☐ Electronic ☐ Paper

This authorization for Release of Information covers the period of healthcare from _____ to_____

Purpose of Disclosure:

_____Continuity of Care (PCP/Specialist)
_____Transition of Care/Second Opinion
_____Personal ____Attorney
_____Employer ____Disability
_____Insurance ____Other

Information Requested:

____Recent/Pertinent Laboratory Results
____Radiology Reports
____EKG report/tracing
____Any Pertinent Medical History
____All the above ___ Dental Records & X-rays

This authorization shall be in force and affect for **365 days** at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Tulip Tree Family Health Care. I understand that a revocation is not effective to the extent that the Tulip Tree Family Health Care has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Tulip Tree Family Health Care will not condition my treatment, payment, enrollment in a health plan or eligibility benefits (If applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

I do not want the following information released / obtained:

_____Alcohol_____Depression_____Hepatitis _____Drugs_____HIV/AIDS_____Sexually transmitted disease

_____ _____
Signature of Patient or Personal Representative / Relationship Date

_____
Signature of Witness