

# Release of Records Form

Reproductive Care of Indiana

Michael A. Henry, M.D.

## Patient authorization for copy and release of records from Reproductive Care of Indiana

I, \_\_\_\_\_  
(Name of Patient)

\_\_\_\_\_  
(Address of Patient)

\_\_\_\_\_  
(Date of Birth) (SS #)

\_\_\_\_\_  
(Patient E-Mail Address)

Hereby authorize Reproductive Care of Indiana to **copy and release my health information to:**

\_\_\_\_\_  
(Name and full address)

\_\_\_\_\_  
(Phone and Fax Number)

This protected health information is being released for the following purposes:

- \_\_\_\_\_ Moving/relocating
- \_\_\_\_\_ Changing physicians (i.e. Release to OB/GYN)
- \_\_\_\_\_ For PCP's records
- \_\_\_\_\_ Other: please list specific purpose \_\_\_\_\_

Please state what portion of your health information record you would like copied and released; for example,

- \_\_\_\_\_ Complete medical record
- \_\_\_\_\_ Partial medical record – pregnancy related information from \_\_\_\_\_ to \_\_\_\_\_
- \_\_\_\_\_ other – please specify – (example: lab reports only) \_\_\_\_\_

### Copying Fees:

RCI will forward your records to a physician one time at no charge. All additional requests will incur a \$20 copy fee. RCI will charge a \$20 copying fee to all requests made by a patient to obtain records for their personal use.

**Please note we may only release records for services provided with RCI. Records will be sent out within 30 days of receipt of this request. If you have not been seen within the past 5 years and your chart is in storage, records will be sent out within 60 days. This consent expires 60 days from the date signed.**

\_\_\_\_\_  
(Signature) (Date)

Office use only – Records Released:

Date: \_\_\_\_\_ To: \_\_\_\_\_ By: \_\_\_\_\_