Authorization to Release Confidential Medical Records

I hereby authorize a copy of my child's medical records to be released **FROM**: Indianapolis Independent Pediatricians, PC
777 Beachway Drive, Suite 210, Indpls, IN 46224
Tel: 317-293-7177 Fax: 317-293-3991

Patient Name(s):_____ Date of Birth:_____

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Dates and Type of Information to Disclose:	**The purpose of disclosure is:**
□ All available medical records	□ Practice Closing

Only medical records originated through Indianapolis Independent Pediatricians, PC will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and includes the date on this authorization unless other dates are specified.

I understand the information in the health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services and treatment for alcohol and drug use.

This information may be disclosed and used by the following individual:

Records To: _____
Address: _____
City, State, Zip: _____
Phone:_____ **Email:**_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand revoking will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

This information is disclosed from records whose confidentiality is protected by Federal law. Federal Regulations 42CFR, Part 2) prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. This consent may be revoked at any time, except to the extent that action has already been taken. A general authorization for the release of medical or other information is not sufficient for this purpose. There is a statutory fee associated with the copying/mailing of this information; 760 IAC 1-71-3.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient (if under 18 years old) / Parent/ Guardian or Authorized Representative **Date**

_____ _____
Printed Name **Relationship / Capacity to patient**

Rev 12/31/2025