Indiana Health GROUP

Authorization to Release Protected Health Information to
Professional Individuals or Facilities

THIS REQUEST WILL NOT BE PROCESSED IF INCOMPLETE!
Partially completed releases will be scanned into your chart for communication purposes ONLY

1) Patient name: _____ D.O.B. _____

2) I am requesting that my medical records be transferred to Indiana Health Group from:

☐ **Jill Lintner, APRN**
LifeStance Health - 10801 North Michigan Road, Suite 200, Zionsville IN 46077
Phone: 317-558-0630
Fax: 317-203-0929

☐ **Mary Beth Winter LLC**

3) Release Records for the following dates of service: ALL

4) Information Requested: Entire Patient Record

5) Purpose of Release: Treatment / Continued Care

6) This request will be valid for one year from the date signed unless I indicate an earlier date or event here _____

By my signature below I understand: This authorization may be revoked at any time by sending written notification to Indiana Health Group at the address listed below. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. Indiana Health Group will not condition my treatment whether I provide authorization for the requested use or disclosure. A copy of this authorization shall be as valid as the original. 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). I have the right to refuse to sign this authorization. I have the right to receive a signed copy of this authorization. Indiana Health Group reserves the right to charge for the reproduction of Medical Records in accordance with state law code 760 IAC 1-71-3. Unless listed above, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding **treatment and related services for alcohol and/or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.**

THIS IS A LEGAL DOCUMENT. Please read and complete carefully. By your signature below you agree that you understand & agree to the terms.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized representative may sign and date the form.
  Please indicate your legal authority and include documentation: ☐ Legal Guardian ☐ Health Care Agent (Health Care Power of Attorney)
- If the patient is under the age of 18, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.
  Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature *(Required)* _____ Date Signed *(Required)* _____

Printed Name of Person Signing this ROI: _____

INDIANA HEALTH GROUP USE ONLY

Received and Reviewed By: _____ DATE: _____

Release was Processed By: _____ DATE: _____