

Hancock Physician Network

I hereby request that all of my medical records be released from:

Name/Organization _____

Address _____

City, State, Zip _____

Please forward records to:

ANDERSON FAMILY PRACTICE
300 E. Boyd Avenue, Suite 120
Greenfield, IN 46140
317-462-3441

HANCOCK PEDIATRICS
300 E. Boyd Avenue, Suite 250
Greenfield, IN 46140
317-467-4500

NORTHEAST MEDICAL GROUP GREENFIELD
1 Memorial Square, #305
Greenfield, IN 46140
317-462-6662

HANCOCK COUNSELING & PSYCHIATRIC SERVICES
180 W. Muskegon
Greenfield, IN 46140
317-468-6200

HANCOCK PHYSICIAN NETWORK - FORTVILLE
600 Vitality Drive
Fortville, IN 46040
317-477-6400

NORTHEAST MEDICAL GROUP GEIST
7962 Oaklandon Rd., #106
Indianapolis, IN 46236
317-823-1883

HANCOCK FAMILY PRACTICE
120 W. McKenzie Rd, #H
Greenfield, IN 46140
317-462-2335

NEW PALESTINE FAMILY MEDICINE
7375 W. US 52
New Palestine, IN 46163
317-861-4171

Patient Name: _____
Last First Middle/Maiden

Address: _____

City, State, Zip: _____

Date of Birth _____ Telephone () _____ Social Security _____

Please release the following information:

<input type="checkbox"/> Provider Notes	<input type="checkbox"/> X-Ray Reports
<input type="checkbox"/> Special Diagnostic Test Results	<input type="checkbox"/> Chemical/Alcohol Treatment Records
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> All Medical Records
<input type="checkbox"/> Billing Records	<input type="checkbox"/> Other (Specify)

Unless **I HAVE LIMITED BELOW**, I understand that this also pertains to records regarding testing and treatment for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or for psychiatric treatment or counseling or communicable disease.

Limitations:

- Confine to summary information from records regarding treatment for the following condition or injury:
_____ On or about [date(s)] _____
- Other: _____

I understand (1) I may revoke this authorization at any time, except to the extent that action has been taken based upon it, as described in the HPN Privacy Notice. (2) That this authorization will expire in 60 days from the date signed, unless I specify otherwise. (3) That the recipient of these records may further disclose information because of this authorization and them it may no longer be protected by the Federal Privacy Regulations, and that HPN would not be responsible for this action, and (4) I am entitled to ask for a copy of this document.

Date: _____ Patient Signature: _____

Signature: _____
(Parent/Guardian/Legal Representative, if patient is unable to sign) (Relationship)

* Please be advised that there may be a fee for processing your request for medical records.
* This is in compliance with Federal HIPAA guidelines.