

**RECORDS TO BE RELEASED FROM:  
Hancock Physician Network, LLC**

**I hereby request and authorize Hancock Physician Network, LLC ("HPN") to furnish records to:**

**Name/Organization** \_\_\_\_\_

**Address** \_\_\_\_\_

**City, State, Zip** \_\_\_\_\_

**Anderson Family Practice**  
300E. Boyd Ave. Suite #120  
Greenfield, IN 46140  
Phone (317) 462-3441

**Hancock Physician Network-Fortville**  
600 Vitality Dr.  
Fortville, IN 46040  
Phone (317) 477-6400

**Hancock Family Practice**  
120 W. McKenzie Suite H  
Greenfield, IN 46140  
Phone (317) 462-2335

**Hancock Counseling & Psychiatric Services**  
120 W. McKenzie St.  
Greenfield, IN 46140  
Phone (317) 468-6200

**New Palestine Family Medicine**  
7375 W. U.S. 52  
New Palestine, IN 46163  
Phone (317) 861-4171

**Hancock Urgent Care**  
8535 N. Clearview Drive Suite #200  
McCordsville, IN 46055  
Phone: (317)-335-6960

**Northeast Medical Group- McCordsville**  
8535 N. Clearview Drive Suite #400  
208McCordsville, IN 46055  
Phone (317) 335-6930

**Northeast Medical Group- Greenfield**  
One Memorial Square Suite # 305  
Greenfield, IN 46140  
Phone (317) 462-6662

**Hancock OB/GYN**  
300 E. Boyd Avenue, Suite  
Greenfield, IN 46140  
Phone (317) 462-1992

**Hancock Pediatrics**  
300 E. Boyd Ave. Suite #250  
Greenfield, IN 46140  
Phone (317) 467-4500

**Hancock Pediatrics-McCordsville**  
8535 N. Clearview Drive Suite #500  
McCordsville, IN 46055  
Phone (317) 335-6950

**Patient Full Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Telephone # ( )** \_\_\_\_\_ **Social Security** \_\_\_\_\_

**Please release the following information:**

**For the purpose**

<input type="checkbox"/> HPN Provider Notes	<input type="checkbox"/> HPN X-Ray Reports
<input type="checkbox"/> HPN Special Diagnostic Test Results	<input type="checkbox"/> HPN Chemical/Alcohol Treatment Records
<input type="checkbox"/> HPN Lab Reports	<input type="checkbox"/> All Medical Records
<input type="checkbox"/> HPN 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 then 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.**