



Medical Records Release Form

By signing this form, I authorize Fiat Family Medicine to **RELEASE** confidential health information about me, by sending a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

The information to be released is as follows:

Initial next to each selection to also include:

_____ Mental Health Information	_____ Genetic Testing Information
_____ HIV/AIDS Information	_____ Substance Abuse Diagnosis/Treatment

Send my protected health information **TO** the following physician/person/facility/entity:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Signature of Patient or Personal Representative

Date

Printed name

Description of Personal Representative

Fiat Family Medicine

Address: 13590-B North Meridian Street, Suite 100 Carmel IN 46032

Fax: 317.740.1016

Phone: 317.676-7858

Email: info@fiatmd.com