AUTHORIZATION TO RELEASE / REQUEST INFORMATION

State Form 46729 (R4 / 4-01)

INDIANA DEPARTMENT OF CORRECTION

CONFIDENTIAL

INSTRUCTIONS: This authorization for release of confidential information is to be completed by the offender or a staff member for the purpose of authorizing the release of information to / from the Department of Correction.

I _____ DOB _____ DOC# _____,
(*Please print*)

FACILITY _____ SOCIAL SECURITY NUMBER _____,

authorize the Department of Correction to ☐ release ☐ request medical / mental health records to / from:

NAME OF PERSON / ORGANIZATION: _____

ADDRESS _____.

I hereby authorize the above named provider to release to the Indiana Department of Correction the following confidential information:

☐ Physician / Provider's summary of my diagnosis, medications, treatments, prognosis and recent care.

☐ Admission	☐ Discharge	☐ Operative Summary Reports
☐ X-Ray	☐ Special Studies Reports	☐ HIV Test
☐ Laboratory Reports	☐ Immunization History	☐ Dental Treatment Records
☐ Psychiatric Summary Report	☐ Drug Treatment History & Counseling Reports	☐ Mental Health Records

☐ Other Records _____

When the Department of Correction requests information, mail to:

The information requested is recognized as confidential and will be used and maintained in the same manner as similar information created within the Department of Correction.

I understand that the information to be released may include HIV infection and Drug / Alcohol documentation. I ☐ certify ☐ do not certify that I have given my consent to release ☐ HIV ☐ Drug / Alcohol treatment records.

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This release will remain in effect for 90 days, unless specified in writing for a shorter time frame.

I make this consent upon the premise that all disclosure made pursuant to the authority granted by this consent shall be accomplished by a written notice and shall be in accordance with all applicable federal and state laws, regulations and rules.

I hereby release the health care provider from any liability which may result from furnishing the information requested as authorized in this release.

I have read the above and foregoing **PATIENT'S CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION** and I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Signature of offender	Date (*month, day, year*)
Signature of witness	Date (*month, day, year*)

DISTRIBUTION: White - Medical Records; Canary - Offender