THE LOGAN INSTITUTE FOR HEALTH AND WELLNESS, LLC
8499 Fishers Center Drive • Fishers, IN 46038
(P) 317-598-4325 (F) 317-598-4326
Email: office@loganmd.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I (the undersigned) hereby authorize **THE LOGAN INSTITUTE FOR HEALTH AND WELLNESS, LLC** to release/retrieve the following identified information:

PATIENT INFORMATION:

Name:_____

Date of Birth:_____SSN:_____

Phone (Home):_____Phone (Cell/Other)_____

_____INFORMATION TO BE RELEASED ***TO*** **THE LOGAN INSTITUTE FOR HEALTH AND WELLNESS, LLC**
TWO (2) YEARS OF RECORDS ONLY PLEASE

AND/OR

_____INFORMATION TO BE RELEASED ***FROM*** **THE LOGAN INSTITUTE FOR HEALTH AND WELLNESS, LLC**

In the space below, please provide us with information as to where we need to send/fax your records, or what records of yours we are to receive from another office.

___ Medication Records ___ Medical/Testing/Lab Results ___ Discharge Summary

___ Other (please specify below):_____

Name (Physician/Other):_____

Address:_____

Phone:_____Fax:_____

Contact Person/Title:_____

I understand that I may revoke this authorization at any time in writing. Otherwise, this consent is valid for a sixty-day (60) period or for the time period specified in I.C.16-4-8. A photocopy of a signed authorization is acceptable, Providing that it is apparent that following the photocopying of the authorization one has not added the signature or the date. I further agree to pay The Logan Institute of Health and Wellness, LLC the actual cost incurred in preparing the copy of the requested information above. I understand that if these record photocopies are delivered to me, I am responsible for paying the fees of the copy service, which are $15.00 for the first ten (10) pages and $0.25 for every page thereafter. I further understand that should I provide copies of any of my medical records from another source (i.e. St. Vincent's Hospital) to The Logan Institute of Health and Wellness, LLC, under Indiana State Law, The Logan Institute of Health and Wellness, LLC cannot release those records back to anyone, including myself.

_____
Patient Signature

_____
Patient Name (please print) Date

Rev. 09/2010