The Christian Hand Center

Date of Request: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient: _____ DOB: _____

Street Address:

_____

City, State, Zip Code: _____

Person to Release Medical Information to:

Name: _____ DOB: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number : _____ Fax Number: _____

AUTHORIZED ORGANIZATION TO SEND MEDICAL INFORMATION

Name: **Christian Hand Center**_____

Address: __**1800 S 3rd St Terre Haute, IN 47802**____

Billing Address: **PO Box 11057, Terre Haute, IN 47801**_____

Phone #: __**812-232-4036**_____

Fax #: ___**812-235-0420**_____

I understand: Authorization will be in effect from the above date to sixty (60) calendar days unless otherwise revoked. CHC is not responsible for re-disclosure of information by authorized persons and the information may no longer be protected by federal or state privacy laws. Revocation must be in writing. CHC is not responsible for information sent prior to revocation of authorization.
I hereby authorize the release of medical records of my treatment as stated above.

Patient: _____ Date: _____

There is a $25 fee that must be paid before we process the request for Medical Records. You may mail it in with the form. We will fax medical records or you may pick them up after we call you to tell you your records are complete.
We have 30 days to produce your records.