Reset Form

AUTHORIZATION TO RELEASE / REQUEST INFORMATION

State Form 46729 (R6 / 5-20)
INDIANA DEPARTMENT OF CORRECTION

CONFIDENTIAL

I _____, date of birth *(month, day, year)* _____, DOC number _____,
(*Please print*)

Facility _____, Social Security number _____,

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

Name of person / organization: _____

Address *(number and street, city, state, and ZIP code)*:_____.

I hereby authorize the above named provider to release the following confidential information:

☐ Physician / Provider's summary of my diagnosis, medications, treatments, prognosis and recent care
☐ Classification / Facility Records
☐ 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 and Counseling Reports
☐ Mental Health Records
☐ Other Records _____

Dates *(month, day, year)*
From To

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. I understand that this authorization will expire in three hundred sixty-five (365) days from the date of my signature, unless otherwise indicated.

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 understand that treatment, payment, enrollment in health program, or eligibility for benefits is not conditioned on signing this form.

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

I have read the above and foregoing 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: Offender Packet