Kristina Thompson, D.O.
1348 Ohio Street • Terre Haute, IN 47807
Phone (812) 232-6628 • FAX (812) 645-0324

ATTENTION: RELEASE OF MEDICAL INFORMATION

I authorize ____

To release to:

Name: ____

Address: ____

____

the medical records of

Name: ______________________________ Date of Birth: _____ / ___ / _______

Address: ____

____

Telephone: (_____) _______________ *Social Security #: ____________________

*** (SSN voluntarily provided)**

Treatment dates: ____

Information to be released (please check information required):

☐Clinic Notes	Summary ☐Doctor	☐History & Physical
☐Progress Notes	Consultations	☐Physician Orders
☐Nurse Notes	☐Urgent Care Center	☐EKG, EEG, EMG
☐Emergency Room	☐Pathology Report	☐X-ray Reports
☐Operative Report ☐Discharge	☐Lab Reports	☐Other

I acknowledge that data to be released may include material that is protected by law. My check mark and my signature below authorize inclusion of information pertaining to:

☐Mental Health	☐HIV / AIDS	☐Not applicable
☐Drugs & Alcohol	☐Genetic Testing	

Reason for request:

☐Patient Care ☐Other ____

I understand the information released is for the specific purpose above and may not be provided in whole or in part to any other agency, organization, or person. I understand a fee may be charged for copying the medical record. I understand that I may revoke this authorization at any time except to the extent that action has already been taken on it. I understand this authorization will automatically expire ninety (90) days from the date of signature.

Date: ____________

____
Signature of Patient or Legal Representative

____
Relationship to Patient

____
Witness