

Authorization for Release of Information
Complies with HIPAA Section 164.508

Form type: Pharmacy

I, **Name:**
 SSN:
 DOB:
 Address (optional):

HEREBY AUTHORIZE:

 Custodian Name:
 Address:

THE USE AND/OR DISCLOSURE OF INFORMATION TO:

 Attorney Name:
 Firm Name:
 Address:

BY AND THROUGH **INDIANAPOLIS LITIGATION SUPPORT GROUP**, 120 E. MARKET, INDIANAPOLIS, IN 46204

FOR THE PURPOSE OF: LITIGATION/LEGAL PROCEEDING

PLEASE RELEASE THE FOLLOWING INFORMATION:

A completed affidavit with a copy of any and all records including, but not limited to, physician's notes, prescription slips, telephone messages, computer printouts of patient's prescription history, billings for all prescriptions care provided, and all other documents in your possession, custody or control.

- I understand that the health record may include information relating to any communicable disease or sexually transmitted disease, AIDS/HIV, behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance to this consent by sending written notice to the custodian listed at the above address.
- I understand the information described above may be redisclosed by the recipient and, in such case, would no longer be protected by the federal Privacy Rule.
- The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

This Authorization expires (60) days from the date of signature below. Once received, the Authorization is otherwise valid until the request is completed.

A copy of this Authorization shall be considered as valid as the original.

(Date)

(Signature)

(Personal Representative/Relationship to Person Represented)

If signed by a representative, please attach a statement of authority to do so.