Request Health Care Records

We want to make it as easy as possible for you to request copies of your medical records. In compliance with state and federal regulations, you must submit your request in writing. It is also subject to a charge. If you have questions please contact us at 219-836-2096

This is a fillable PDF - Please fill in text boxes and read instructions at end of page.

PATIENT INFORMATION

Patient Name (Last, First. Middle Initial)

Birthdate XX/XX/XXXX

Medical Record Number:

Address

City | State | Zip Code | Telephone # XXX-XXX-XXXX

INFORMATION REQUESTED: I authorize the Midwest Neurology & Associates LLC to use or disclose the following health information during the term of this Authorization: (check all that apply)

- Clinic visit notes
- Surgical (operative report)
- Imaging (Specify Test Results Xray, Ultrasound, etc)
- Complete Medical Record
- Billing Record
- Workers Compensation record
- Other

RECIPIENT AND PURPOSE: If this information is not being delivered to me, then deliver my health information to: (for example: insurance company, school, attorney)

Name of Person

Name of Organization

Organization Address

City | State | Zip Code | Telephone # XXX-XXX-XXXX

The purpose of the disclosure is: (for example: workers' compensation claim review; school requires immunization records; request of patient)

STEP 1: To request your medical records, download the Authorization for Disclosure of Protected Health Information Form.
STEP 2: Once downloaded, the form can be filled out electronically, or printed and filled out by hand. Please remember to sign the form. We are unable to accept e-signatures, stamps or a typewritten name.
STEP 3: Submit your request to Midwest Neurology & Associates, PC through one of these three simple methods.

- Submit your request by email: mwneuro@mwneuro.com??
- Fax your request to: 219-836-2097
- For Questions, please call 219-836-2096.
- The turnaround time to receive your medical records is typically 5-10 business days depending upon your request; however, we strive to complete as soon as possible.

Midwest Neurology Associates, P.C.

1100 Joliet St, # 201 Dyer, Indiana 46311
219-836-2096 mwneuro.com

PLEASE READ THIS PAGE CAREFULLY

SPECIFIC CONSENT

By checking any of the boxes below, I am specifically authorizing Midwest Neurology & Associate, LLC to use and/or disclose the category of confidential information indicated next to the box, if applicable to this authorization.

- ☐ Information about a Mental Illness or Developmental Disability**
- ☐ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about Communicable Diseases
- ☐ Information about Sexually Transmitted Disease(s)
- ☐ Information about Substance (i.e., alcohol or drug) Abuse
- ☐ Information about Abuse of an Adult with a Disability
- ☐ Information about Sexual Assault
- ☐ Information about Child Abuse and Neglect
- ☐ Information about Genetic Testing
- ☐ Information about Infertility/IVF/Artificial Insemination

EFFECTIVE DATE OF AUTHORIZATION

This authorization will remain in effect under the following conditions: (check one preference)

☐ From the date of this Authorization until the following date: _____

☐ Until the purpose is fulfilled.

☐ Until the following event occurs: _____

☐ Other (e.g. no expiration): _____

Note: The term for mental health records must be stated—you may not use "no expiration." If no termination event is filled in, then this Authorization will expire 90 days after the date signed below

I understand that I may change my mind and revoke this Authorization in writing at any time by notifying the HIPAA Program Office. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that any Midwest Neurology & Associates PC has already taken action where it relied on my permission. Send revocations to: HIPAA Program Office, 1100 Joliet St, Suite 201, Dyer, IN 46311

I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient, no Midwest Neurology & Associate PC can guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.
I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be effected unless (a) the only purpose of treatment is to create health information for the disclosure listed above, or (b) if my treatment is related to my participation in a research study.
I have read and understand this Authorization and had a chance to ask questions about the disclosure of the health information. I authorize Midwest Neurology & Associate PC to use/disclose my health information in the manner described above.

Signature of Patient or Personal Representative* _____ Date _____

Name of Personal Representative* (if applicable) _____ Relationship to Patient _____

*The Personal Representative is the patient's durable mandate. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.

**A witness signature is required for the release of information about a mental illness or developmental disability.

Signature of Witness: _____ Date _____