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 - Pleaes fill in the text boxes and read instructions at the end of the page.

Patient Information
Patient Name (Last, First, MI)

_____

Birthdate xx/xx/xxxx

_____

Address

_____

City _____ State _____ ZIP Code _____ Telephone # xxx-xxx-xxxx _____

INFORMATION REQUESTED: I authorize the Midwest Neurology Associates, P.C. 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 this disclosure is: (for example: workers' compensation claim review; school requires immunication records; request of patient

_____

Patient Authorization Signature _____ Date Signed _____

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 htrough one of these three simple methods

- Submit your request by email: mwneuro@mwnero.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 pending 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 Associates, P.C. 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 Diseases
- ☐ 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, P.C. has already taken action where it relied on my permission. Send revocations to: HIPAA Program Office, 1100 Joliet Street, Suite 201, Dyer, IN 46311.

I understand that I may 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 Associates 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 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 the 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 Associates 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
Signature of Witness	Date
Name of Witness	

Midwest Neurology Associates, P.C.

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