MULLALLY
SPORTS & FAMILY MEDICINE

MEDICAL RECORDS AUTHORIZATION

Indiana Sports & Medical Science Institute, PC
****outside providers to send MR to ISMSI**

Patient's Name: _____ DOB: _____

Previous Name: _____ SS#: _____

I request and authorize:

Name of Physician: _____

Phone: _____ Fax: _____

to release my healthcare information to:

Indiana Sports and Medical Science Institute, PC
11275 Delaware Parkway
Suite A
Crown Point, IN 46307
ph: 219.779.8735 fax: 877.715.2312

This authorization applies to:

◯ healthcare information relating to the following treatment, condition, or dates: _____
_____

◯ ALL healthcare information

◯ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes simplex, human papilloma virus, warts, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV, AIDS, and gonorrhea.

◯ yes ◯ no I authorize the release of my STD results, whether positive or negative, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these results to anyone.

◯ yes ◯ no I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____
Patient Signature or Authorized Representative Date Signed

This authorization expires 90 DAYS after it is signed.