Medical Records Release Form

To ensure that your medical records are held in confidentiality, please be explicit to where you want them sent.

Name:_____ Date of Birth:_____

Primary Phone:_____(Check One: ☐Home ☐Mobile ☐Work ☐Other)

Please transfer my medical records as follows:

From:_____

To: NuStart (Dr. Jamie N. Lindsay); 797 S. Wabash St, Wabash, IN 46992; 260.274.0134 (fax)

Records to be released (check applicable):	Reason to be released (check applicable)
☐ All medical records	☐ Transfer of care
☐ Other:_____	☐ Other:_____

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent. Please initial below if you DO NOT want any of the following records released. All applicable records will be released if nothing is marked.

☐ Drug and/or alcohol abuse, diagnosis or treatment	☐ HIV/AIDS testing and/or treatment
☐ Confirmed STI test results and/or treatment	☐ Psychiatric care and/or mental illness

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_____
Signature

_____
Witness

_____
Date